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MANAGING THE CHAMPUS OUTPATIENT MARKET: A MARKETING ASPECT

A Graduate Management Project

Submitted to the Faculty of

Baylor University

In Partial Fulfillment of the

Requirements for the Degree

of

Master of Healthcare Administration

by

Captain Ray E. Horn, U.S. Army, MS

July 1993

Expected Graduation Date: August, 1993

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ABSTRACT

At the direction of Health Services Command (HSC), Brooke Army Medical Center (BAMC) will soon enter a new realm of healthcare delivery known as "Gateway to Care." The Department of Defense (DoD) refers to the same program as the Coordinated Care Program (CCP), while the civilian medical community refers to the same program as Managed Care. User understanding of this program will increase its cost effectiveness and make the implementation process easier. This paper addresses some considerations for recapturing and facilitating the management of the CHAMPUS outpatient population.

Marketing efforts explaining the Gateway to Care program to the commanders and staff of medical treatment facilities appear to be progressing satisfactorily; however, the beneficiary population seems to be unclear about the program and its benefits. An extensive amount of publicity has been given to the program in general, however, limited definitive research has been directed at the particular areas in which BAMC should concentrate its primary care efforts in terms of high-cost/high-volume users.

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INTRODUCTION

Brooke Army Medical Center (BAMC), as well as the other Health Services Command (HSC) medical treatment facilities (MTFs), will soon be embarking on a new journey for healthcare delivery. According to the former Assistant Secretary of Defense for Health Affairs, Dr. Enrique Mendez, the goals of the Coordinated Care Program (CCP) are to: (1) improve beneficiary access to health services, (2) ensure quality care is provided to all beneficiaries of the Military Health Services System (MHSS), and (3) contain health care costs (OASD[HA], 1992). Containing costs while improving quality and access will present the biggest challenge to BAMC in accomplishing the "Gateway to Care" (GTC) mission. One crucial aspect of this challenge is to recapture a percentage of the outpatient CHAMPUS expenditures.

Cost containment has been scrutinized from several viewpoints, and a wide-range of recommendations have been made. Some of the more common ideas include: (1) reducing services, (2) reducing the beneficiary categories that we serve, (3) increasing the quantity of care at the expense of quality, and (4) reducing

extreme external expenditures. The letter from The Surgeon General, Lieutenant General Alcide M. LaNoue, to the Commander, Health Services Command, Major General Richard D. Cameron, provides the guidance that reducing services is not an option. The "Doomsday Letter," Appendix A, is based on guidance to the TSG from the Department of Defense (DoD). The impact to BAMC for FY94 would be a budget reduction of approximately $15.5 million. We also can not eliminate any of the eligible beneficiary categories, as they are mandated by DoD. An example of this would be eliminating appointments for retirees and/or their dependents. Other ideas may include such measures as cutting appointment times by half (30 minutes to 15 minutes) or reducing credentialing standards. Clearly, increasing quantity at the expense of quality is not a reasonable alternative. However, the reduction of extreme external costs does provide a means for BAMC to accomplish some of the goals of the CCP and to minimize the impact of the Doomsday Letter requirements.

CONDITIONS WHICH PROMPTED THE STUDY

The initial stimulus for this study was the implementation of the Gateway to Care program at Brooke

Army Medical Center (BAMC) at the beginning of fiscal year (FY) 1994 and the need for BAMC to have a marketing plan ready to activate. The scope of the study changed in order to narrow the focus of the management problem.

Statement of the Management Problem

The problem is to identify BAMC's high-cost and high-volume outpatient CHAMPUS services and to recommend a marketing strategy to facilitate cost containment for these areas.

Literature Review

There is an abundant resource of information available on marketing strategies and global marketing perspectives. However, the definitive mechanisms for the "how" as opposed to the "what" are not clearly stated in the majority of the literature. For this reason, one particular marketing aspect of GTC will be the focus of this paper. The problem that military healthcare recipients address most often is access. This is apparent when reviewing the three dimensions of the CCP: access, quality, and cost-containment (Mendez, 1992).

The Health Care Advisory Board, Washington, D. C., performed over 110 interviews with experts in the area of health care marketing. Their sources included over 70 hospitals and numerous consultants, vendors, and trade associations. Their study also reviewed over 2000 pages of articles and more than 100 custom research reports on strategies to market hospital services (Ashman, 1991). In several instances, they found the customers were more concerned with high quality and easy, rapid access rather than a cost which may be a fraction higher than the normal. Some of the results indicated that cost was a significant factor in the selection of the facility/provider. Inpatient utilization is declining (Andersen, 1991), while outpatient visits are rapidly increasing (Lumsdon, 1992).

Other literature suggests that part of the targeting scheme for managed care depends on the identification and enrollment of the beneficiary population in order to determine the medical resources required to meet the needs and demands of the eligible beneficiaries (Badgett, 1990; Kongstvedt, 1989; Saward & Fleming, 1980). The success or failure of the

identification and enrollment process will be greatly influenced by the initial marketing efforts and strategies. Kotler (1989) suggests that the market should be segmented, targeted, researched, appraised, and developed. Bensky (1990) states that information on the target market includes awareness of current and potential competition and determining whether substitutes for the services are available. Bensky also believes that the next step is to determine what values will motivate the user of the services to participate in your plan/program.

In a recent survey by the American Hospital Association (AHA/CMHS Inventory of General Hospital Mental Health Services), it was found that managed care has a significant impact in the mental health field (Murray, 1993). The survey queried 1,829 psychiatric programs from 1988-1990 and though dramatic increases in capital expenditures were not apparent, it did discover that outpatient services for children and adolescents are becoming an area of intensive resource focus. The survey also indicated a trend toward privatization of mental health treatment facilities from state and local facilities.

Grayson (1993) argues that price controls are not an effective method for managing health care costs, but the application of total quality management and benchmarking can improve the quality of the services provided while reducing costs. Shortell (1993) believes that primary care is the core to health reform initiatives. His view is simple, "to succeed in the marketplace of the future, hospital systems must shift their paradigms from acute care to primary care."

According to Taylor (1993), contract management is the key to the successful implementation of contracts for services. The survey conducted by Hospitals magazine polled 1,185 respondents on the three most commonly used contract services: clinical departments, hospitality services, and business services. The results indicate that about 75% of the hospitals use regional contract management firms for clinical services with 59% being "highly satisfied" with the management.

Background Information

Several alternatives can be investigated to reduce or contain costs. For instance, there may be a better method to utilize our internal assets and reduce or

closely monitor external contracts. Restructuring the Department of Nursing to eliminate some of the middle level administrative slots could eliminate part of the need for contract nurses. A telephone conversation in September 1992 with LTC Bill Mantia, Chief, Coordinated Care Division, Fort Carson, CO indicated that the Fort Carson MTF has already exercised this option. The Fort Carson MEDDAC has also demonstrated that by redirecting their focus and resources, they can provide more services and minimize patient visits. This represents a shift from the inpatient focus to the ambulatory care/outpatient focus. Hiring a wage grade employee to maintain supply stocks on the wards would realistically free the higher paid non-commissioned officers to become more patient care oriented and thus, reduce the need for contract licensed practical nurses (Moore, 1993).

Another proven possibility is to reduce fraud, waste, and abuse through intense monitoring of contracts (Beers, 1992). As an internal auditor and assisting officer in an investigation, Mr. Beers revealed that the contractor had overcharged the government by approximately $28,000 during the first

four months of the contract. His investigation also revealed that potential savings could exceed $1.2 million dollars over the life of the contract. Closely tied to the better use of internal resources is the reclamation of the high-cost/high-volume CHAMPUS outpatient users; in essence, developing a better managed care program.

The success of any managed care program depends on the identification and enrollment of the beneficiary population in order to determine the medical resources required to meet the needs and demands of the eligible beneficiaries (Badgett, 1990; Kongstvedt, 1989; Saward & Fleming, 1980). The success or failure of the identification, registration, and enrollment process will be greatly influenced by the initial marketing efforts and strategies. In preparing the foundation, the Commanding General, Brigadier General Zajtchuk, published the letter, Appendix B, to beneficiaries.

In the identification and registration processes, we anticipate the identification of what has been termed the "ghost population." The "ghost population" represents the unknown user portion of beneficiaries who for some reason (geographical, seasonal) are very

mobile and move from one area to another and expect to receive care at the new location. The ability to plan for this element will add flexibility and strength to our system of delivering health care.

Just as the HSC Commander has encouraged the MTFs to begin marketing their future plans, the success of BAMC's effort to recapture the high-cost/high-volume user will depend largely upon our ability to do several things. We must accurately identify the consumer population, identify the customer needs, tailor a customer-oriented health care delivery package, and educate the providers, staff, and consumers about the advantages of participating in the Gateway program.

Marketing efforts must be aimed not only at the beneficiary population, but should also be expanded to encompass the providers of the care and the affiliated participants in the program. A copy of the proposed marketing/public affairs plan is located at Appendix C. The health care provider team which includes the BAMC staff, agency hires, partnership providers, and contract providers will require intense marketing efforts in terms of education about the "Gateway Mission." Kotler (1989) suggests that the market

should be segmented, targeted, researched, appraised, and developed.

This paper addresses the target population (outpatient CHAMPUS users) and researches the costs associated with BAMC's inability to provide services which meet the needs of the beneficiary population. To date, there has been very limited action to gain control of the outpatient population. The three primary segments of the population that should be targeted, in order to gain control of the outpatient population, are the CHAMPUS users, BAMC's staff, and the providers and facilities outside of the DoD network that we will attempt to enjoin for their services.

The Defense Medical Information System (DMIS) separates outpatient care into four major categories (obstetrics, medical, surgical, and psychiatric) for determining CHAMPUS patient load. This data creates a base for the investigation. A review of government cost for ancillary services for CHAMPUS users is then reviewed. The four major categories of care are sub-divided into thirty-two clinical settings (DMIS,1991) and evaluated in terms of paid professional cost and visits. Finally, a review of CHAMPUS costs for

psychiatric services between FY91 and FY92 is conducted.

As the CCP begins, we must: (1) identify our area of responsibility, (2) know our eligible beneficiaries, (3) know our principal CHAMPUS users, (4) have a reliable enrollment program, (5) know what we can offer our beneficiaries (The Triple Option), and (6) consider the problems associated with overlapping catchment areas. Enrollment in coordinated care is mandatory for all active duty personnel and optional for active duty family members, retirees, dependents of retired military, and eligible survivors of active duty and retired personnel living within a 40 mile radius of a military treatment facility offering coordinated care (Mendez, 1992). The 40 mile radius is referred to as the military hospital's catchment area.

The BAMC catchment area encompasses all of Bexar County and surrounding communities. A significant portion of the BAMC's catchment area overlaps Wilford Hall Medical Center's (WHMC) catchment area. These two areas are referred to as the San Antonio Military Community Service Area (SAMCSA).

Eligible Beneficiaries

While BAMC and WHMC catchment areas overlap almost entirely, the eligible beneficiary populations have been separated by zip code by the Resource Analysis and Planning System (Grems, 1991). Thus, the eligible beneficiary population in BAMC's catchment area is excluded from WHMC's catchment area and vice versa. Population data for eligible beneficiaries within the BAMC catchment area was extracted from the DMIS FY91 Population Report. Table 1 depicts the population data for the BAMC catchment area.

Table 1 BENEFICIARY POPULATION

Active Duty Military	15,698
Dependents - Active Duty	24,912
Reserve Component	1,351
Dependents - Reserve Components	2,013
Retirees	20,221
Dependents - Retirees	26,529
Survivors and Others	5,186
Total	95,910

Of the 95,910 total beneficiaries in this catchment area, 28 percent are dependents of retired military, 26

percent are active duty dependents, 21 percent are retired military, 16 percent are active duty military, 5 percent are eligible survivors of active duty and retired personnel, and the 4 percent are reserves and their dependents. The WHMC beneficiary population according to the DMIS FY91 Population Report is 81,407, considerably smaller than BAMC's. The distribution of beneficiaries in each of the categories is relatively similar. Appendix D compares the BAMC population by category to that of WHMC. The sole purpose for observing WHMCs beneficiary population in this paper is to establish the need of the two organizations to share resources to gain control over the high-cost/high-volume users.

Utilization of the Resource Analysis and Planning System (RAPS) facilitates planning for the 177,317 eligible beneficiaries in the SAMCSA and decreases beneficiary confusion in terms of which facility to use. The RAPS divides the catchment areas for WHMC and BAMC by a pre-established zip code methodology. If used, WHMC would be responsible for the 81,407 beneficiaries that are residing within its catchment area, and BAMC would remain responsible for its

population of 95,910 beneficiaries. As the CCP evolves, it may become necessary to modify catchment areas in order to maximize the use of the military health care resources within the service area and increase cost efficiency. This can be accomplished by eliminating some duplication of services and standardizing others. As an example, the WHMC and BAMC pharmacies have developed a standard formulary.

CHAMPUS Users

Extending the control over the spending of CHAMPUS funds is a key feature of the CCP. The "Executive" or "Lead Agent" of the SAMCSA would be given control over both CHAMPUS and direct medical care budgets for the overlapping catchment areas. The purpose of this action is to establish plans that make the most cost-effective use of military and private sector care.

At the present time, it appears that WHMC will be the designated "lead agent" and that presents its own set of problems for BAMC. Only 59 percent of the individuals in the BAMC catchment area are Army beneficiaries, while 35 percent are Air Force. The relatively large number of Air Force beneficiaries in the BAMC catchment area may be explained by the four

Air Force Bases (Randolph, Lackland, Kelly, and Brooke) in the SAMCSA as compared to one Army installation, Fort Sam Houston (Grems, 1991). Enrollment of high volume CHAMPUS users into the CCP should optimize the use of the military resources and decrease the cost of care reimbursed under CHAMPUS. The two biggest concerns are the high volume and high dollar procedures that could possibly be brought into the MTFs.

There are 63,855 CHAMPUS eligible beneficiaries in the BAMC catchment area. The total number of CHAMPUS user beneficiaries for BAMC was extracted from the CHAMPUS Health Care Summary for October 1990 through September 1991. During this twelve month period, the total user beneficiary population for CHAMPUS outpatient care was 28,158 with 115,156 total visits. The total cost to the government was $11,236,695, (Appendix E). This indicates that 44% of the eligible CHAMPUS beneficiaries were responsible for the total cost and that each user averaged 4.08 visits during this time frame. The average cost per visit per patient averaged $399.00.

Outpatient professional services were reviewed by beneficiary category, sponsor service, and visits to

determine the workload being handled by CHAMPUS expenditures (Table 2, p17). Four primary areas were reviewed: Obstetric, medical, surgical, and psychiatric visits. Data on the cost per outpatient procedure per clinic was not reviewed; however, this data was examined to determine the most frequent users of the CHAMPUS system by beneficiary category (Table 2, p17).

TABLE 2

CHAMPUS OUTPATIENT PROFESSIONAL VISITS

SPONSOR SERVICE	BENEFICIARY CATEGORY	OBSTETRIC VISITS	%	MEDICAL VISITS	%	SURGICAL VISITS	%	PSYCHIATRIC VISITS	%	TOTAL	%
ARMY	DEP OF ACTIVE DUTY	10	35.71%	11,849	27.23%	8,827	29.80%	13,278	31.64%	34,166	29.53%
	RETIRED	0	0.00%	2,847	6.55%	1,173	3.96%	2,234	5.32%	5,959	5.15%
	DEP OF RETIRED	1	3.57%	6,485	14.90%	4,384	14.80%	7,749	18.46%	18,628	16.10%
	SURVIVOR	1	3.57%	1,020	2.34%	691	2.28%	1,441	3.43%	3,153	2.73%
Sub-total		12	42.86%	21,991	50.33%	15,280	50.69%	24,702	58.85%	61,906	53.51%
NAVY	DEP OF ACTIVE DUTY	0	0.00%	703	1.62%	473	1.57%	816	1.94%	1,992	1.72%
	RETIRED	0	0.00%	321	0.74%	131	0.43%	95	0.23%	547	0.47%
	DEP OF RETIRED	2	7.14%	876	2.01%	618	2.02%	902	2.15%	2,380	2.07%
	SURVIVOR	0	0.00%	109	0.23%	38	0.13%	161	0.38%	299	0.26%
Sub-total		2	7.14%	2,009	4.60%	1,252	4.13%	1,974	4.70%	5,228	4.52%
AIR FORCE	DEP OF ACTIVE DUTY	12	42.86%	8,105	18.63%	6,939	22.99%	7,311	17.42%	22,369	19.33%
	RETIRED	0	0.00%	3,186	7.33%	1,778	5.89%	1,371	3.27%	6,337	5.48%
	DEP OF RETIRED	2	7.14%	6,638	15.34%	4,036	13.37%	4,959	11.82%	15,627	13.51%
	SURVIVOR	0	0.00%	674	1.55%	329	1.09%	804	1.92%	1,798	1.55%
Sub-total		14	50.00%	18,889	43.74%	13,071	43.30%	14,445	34.42%	46,131	39.87%
MARINES	DEP OF ACTIVE DUTY	0	0.00%	216	0.50%	107	0.35%	274	0.65%	607	0.52%
	RETIRED	0	0.00%	135	0.31%	137	0.45%	44	0.10%	316	0.27%
	DEP OF RETIRED	0	0.00%	471	1.08%	222	0.74%	379	0.90%	1,072	0.93%
	SURVIVOR	0	0.00%	14	0.03%	7	0.02%	2	0.00%	23	0.02%
Sub-total		0	0.00%	836	1.92%	483	1.60%	699	1.67%	2,018	1.74%
OTHER	DEP OF ACTIVE DUTY	0	0.00%	89	0.21%	21	0.07%	38	0.09%	148	0.13%
	RETIRED	0	0.00%	22	0.05%	12	0.04%	15	0.04%	49	0.04%
	DEP OF RETIRED	0	0.00%	67	0.15%	57	0.19%	94	0.22%	218	0.19%
Sub-total		0	0.00%	178	0.41%	90	0.30%	147	0.35%	416	0.36%
TOTAL		28	100.00%	43,948	100.00%	30,166	100.00%	41,967	100.00%	115,700	100.00%

Enrollment Program

Enrollment into the CCP is basically a three-step process and will be very significant in the marketing effort. The initial step in the enrollment program is to accurately identify all eligible beneficiaries. The identification step uses the Defense Enrollment/ Eligibility Reporting System (DEERS) as a base-line for determining the population size. The next step is to register the population being serviced.

Registration uses the DEERS database information and combines it with Health Risk Appraisals to get a general overview of the health of the population being serviced. Registration does not guarantee services to anyone. It merely provides a tool for the command to utilize in managing the CCP.

Enrollment in coordinated care is only open to eligible beneficiaries who are registered with DEERS (Mendez, 1992). The enrollment process is currently unresolved for the SAMCSA due to the confusion associated with overlapping catchment areas. It will be essential for WHMC and DAMC to utilize the same enrollment processes in order to simplify the program to the beneficiaries.

Enrollment in coordinated care is not mandatory except for active duty members who will be enrolled automatically. Active duty dependents will be given the option of enrolling in coordinated care or relying on CHAMPUS. Retirees, retiree dependents, and eligible survivors will be given the opportunity for enrollment only if a sufficient provider network capacity exists within the WHMC and BAMC catchment areas. Enrollment can not begin until such time that a network of providers has been established and is available for the enrolling population. The enrollment process for other than active duty will be conducted in phases in the order designated above.

Medicare eligible beneficiaries may be enrolled in coordinated care and receive care at a MTF if services are available. Some of the graduate medical education programs will necessitate the enrollment of a small percentage of this category. If services are not available, Medicare eligible beneficiaries will be referred to civilian providers who accept Medicare reimbursement. The pinnacle of the enrollment program will be to deliver the most expedient, cost-effective, high quality care through a carefully structured, well-

organized, provider network.

The Triple Option

Eligible beneficiaries of the CHAMPUS program will have the ability to choose from one of three options being offered by DoD for continued healthcare: cc-plus, cc-extra, and cc-basic. The cc-plus package provides for all healthcare to be received at uniformed service facilities or designated civilian network providers. The cc-extra package allows beneficiaries to use a civilian preferred provider network on a case-by-case basis, and the cc-basic allows beneficiaries to remain under standard CHAMPUS arrangements. The major issue with this range of services is the inability of the local commanders to have some negotiable influence with the programs being offered.

Overlapping Catchment Areas: Special Considerations

Coordinated care planning for overlapping catchment areas presents a particularly complex marketing situation and intensifies the need for extensive interservice coordination (Reischauer, 1991). Coordinating the participatory role of the other MTFs within the service area, delineating responsibility, and establishing accountability will be issues that

will have to be resolved prior to implementing coordinated care in these areas (Mendez, 1992).

Success of the CCP in the San Antonio area will also depend upon the establishment of a formal memorandum of agreement. At a minimum, the memorandum of agreement should address the following issues:

1. The responsibilities of WHMC,

2. The responsibilities of BAMC and the other facilities in support of the coordinated care effort.

3. The apportionment of CHAMPUS funds between WHMC and BAMC,

4. The overhead costs attributable to enrolling Air Force beneficiaries in the BAMC catchment area due to the large Air Force population,

5. The reimbursement of funds for referral services between MTFs within the SAMCSA, and

6. The responsibilities of the lead agent to the other facilities, and vice versa.

The responsibilities and goals of BAMC, WHMC, and the other MTFs within the service area must be clearly defined. While overlapping catchment areas may complicate the coordinated care concept, it also provides the MTFs within the San Antonio area the

opportunity to accomplish several DoD objectives: (1) work together in developing and building an integrated, cost-effective health care system; (2) optimize the use of the military and civilian health care resources in local community; and (3) in some cases, eliminate the duplication of services. Another significant problem is apparent in the mission of BAMC and WHMC, as both are tertiary and graduate medical education (GME) institutions as opposed to primary care facilities.

PURPOSE

The purpose of this GMP is to review some considerations for re-capturing part of the high-costs and high-volume users who contribute to the $11 million CHAMPUS outpatient costs. Data for CHAMPUS outpatient visits, costs, and types of services will be reviewed to determine their impact on the outpatient CHAMPUS budget.

Visits are the most significant variable. They impact not only on the total costs but also on the clinical setting/type of services rendered. Visits are observed in total quantities per beneficiary category. Repeat visits to a clinic could indicate possible churning by the physicians, a wrong diagnosis and

treatment regiment, or even the establishment of a niche through a particular segment of the population.

The next variable is costs. Costs are related to visits and services through several mechanisms. Examples of costs include personnel, equipment, facilities, and supplies. In that DoD does not yet consider these aspects, it will become imperative in the future as military healthcare is forced to operate more like a business. For this report, costs are expressed as totals for professional services. The Tri-Service CHAMPUS Statiscal Database Financial Support System (FASS) provides the capability to monitor costs per clinic per procedure by using Current Procedural Terminology-4 (CPT4) coding. The CPT-4 codes for the adolescent child psychiatry clinic are studied to determine which if any of the procedures are responsible for escalating psychiatry costs.

Type of service is the final variable that is observed. Four major outpatient categories of care (obstetrics, medical, surgical, and psychiatric) are identified by the DMIS database. Thirty-two clinical settings have been identified by the Health Care Studies Institute for outpatient care.

The thirty-two clinical settings are listed below:

- adverse reactions
- allergy
- cardiology
- dental
- dermatology
- endocrinology
- ENT
- family practice
- gastroenterology
- general practice
- general surgery
- gynecology
- hematology
- infectious disease
- internal medicine
- nephrology
- neurology
- neurosurgery
- nutritional
- obstetrics
- ophathamology
- orthopedics
- other*
- pediatrics
- physical therapy
- plastic surgery
- proctology
- psychiatric
- pulmonary/respiratory
- rheumatology
- thoracic surgery
- urology

*not elsewhere classified

One of the clinical settings, psychiatric services, is selected to further narrow the scope of the investigation. Psychiatric services consists of six clinics (psychiatric, psychology, child guidance, mental health, social work, and substance abuse/ rehabilitation). The adolescent psychiatric clinic has ten CPT-4 codes that are studied to determine which of the clinical procedures are high-costs/high-volume. The code names are:

-Consultation With Family
-Evaluation of Tests/Records
-Medical Psychoanalysis
-Psychiatric Therapy/Service
-Special Family Therapy
-Diagnostic Interview
-Individual Psychotherapy
-Pharmacology Management
-Psychological Testing
-Special Group Therapy

The categories of care and the various clinical settings are basically self-explanatory with their name. For the purpose of this report, they are not necessarily viewed as one entity or as part of another. They are observed to provide an indication of the areas in which high-cost or high-volume usage is apparent.

METHOD AND PROCEDURES

Data was gathered from the DMIS information data base in Arlington, VA. and the FASS, U.S. Army Health Care Studies, Fort Sam Houston, TX. Two primary events are of interest in the analysis of the data, outpatient CHAMPUS visits and the costs associated with them. The project is designed to take a simple quantitative view of costs and visits. Using the Pareto Principle, the data, from the information systems listed above, has been analyzed and studied in accordance with the "80-20 rule" to determine the areas of CHAMPUS outpatient spending on which we need to focus our resources.

The Pareto Principle (Chase, 1992) is derived from the 18th century sociologist and economist, Villefredo Pareto, known primarily for his theories on political behavior. Pareto believed that all societies are governed by a small group of rulers who control the

majority of the wealth. In a study of the distribution of the wealth of Milan, Pareto found that 20 percent of the people controlled 80 percent of the wealth. This same logic of the few having the greatest importance and the many having little importance has been broadened to include many situations and is termed the Pareto Principle. It is used in business and industry as a model to identify the few problem areas that create the most significant impact. The healthcare industry uses this problem solving technique as well.

The data being studied is both valid and reliable in as much as it pertains to a particular timeframe. It provides a basis for comparing various FYs with one another, or with FY89, the accepted base year. The base year is defined as the year in which all other data will be compared. The only significant variable that is skewed is the total cost for psychiatry visits. Currently, DMIS is unable to distinguish the outpatient cost per visit from the inpatient cost per visit, and consequently, the total psychiatric costs includes inpatient visits (visits by the doctor at the bedside, not inpatient admissions).

The application of the Pareto Principle will provide a method for determining which, if any, of four basic categories of professional services are creating the most significant expenditure problems. The data in Appendix F compares FY91 and FY92 professional services costs and visits for thirty-two clinic settings, as identified by DMIS. The ABC planning method is used to prioritize these settings, first by the total number of visits and then by cost per visit (assuming there could be a difference). The purpose was determine high-cost/ high-volume clinics. Analysis was also conducted to determine the average cost per visit per clinic.

The FY91 and FY 92 MEPRS Workload and Expense Totals by Psychiatric/Mental Health Care Functional Category for BAMC for each of the categories for each fiscal year are examined using a comparative analysis to determine increases or decreases in expenses and visits. Six clinical categories exist in psychiatric services.

One of the six categories, Adolescent Psychiatric Care, is then examined by using Current Procedural Terminology-4 (CPT-4) codes to determine the most expensive and most utilized procedure in this category.

Again, the Paretto Principle will be used to rank order the CPT-4 codes.

Utilization of the CHAMPUS outpatient visits data (CHAMPUS Health Care Summary) can provide information on which clinical entry points, if any, may need to be expanded to accommodate the possible increase of patients. It is expected that BAMC will later conduct one or more surveys in an attempt to focus more clearly on a distinguishable market. Trial enrollment procedures have already been tested for approximately fifty BAMC active duty personnel and their families. This is one of several trial runs that the coordinated care division will attempt.

RESULTS

BAMC suffers from a tremendous space problem as well as being more tertiary care oriented than primary care oriented. The physical layout of the facilities promotes inefficiency, hampers record keeping accountability, and causes duplication of some services. These facts could possibly be contributing factors to the seemingly high-costs/high-volume usage of CHAMPUS outpatient services.

Tables 1-2 were discussed in the introduction and background information to establish a base for this investigation. In table 1, p.12, population comparisons were made to determine the largest beneficiary category. The categories were then rank ordered in terms of size. From largest to smallest, the results were: dependents of retirees, active duty dependents, retirees, active duty, survivors, and reserve components. An analysis of the data in Table 1 indicated that the three most largely populated beneficiary categories are dependents of retirees, dependents of active duty, and retirees, respectively, and account for 75% of the population being serviced by BAMC. Graph #1, p.32, illustrates the magnitude of three largest beneficiary categories.

Table 2, p.17, examined the CHAMPUS outpatient professional services by sponsor service, beneficiary category, and the professional service by visits that was rendered. The analysis revealed that the Navy and Marines, follow a similar usage-to-population ratio for dependents of retirees and dependents of active duty, respectively, utilizing the majority of the services. It also identifies a user percentage rate for each of

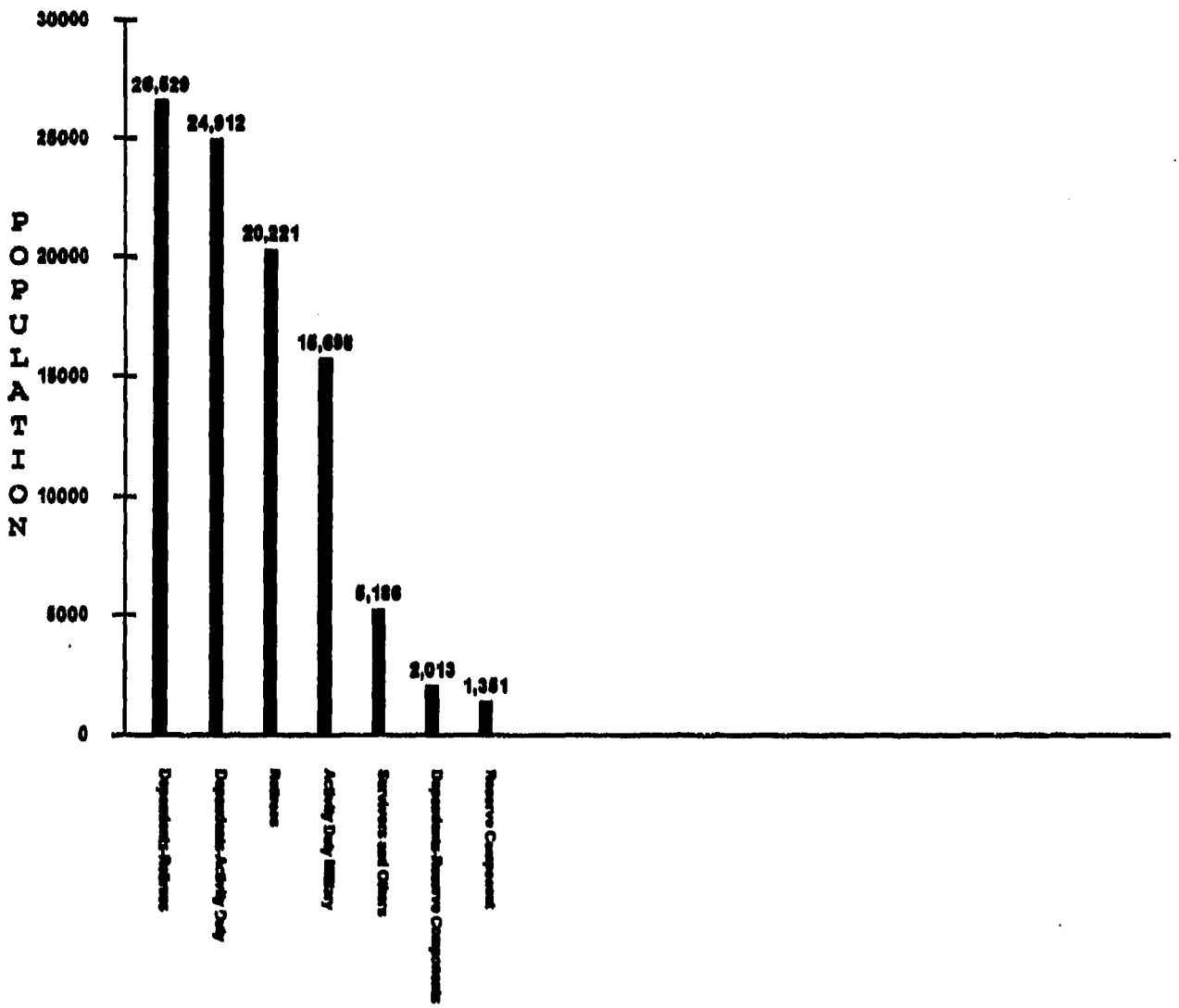
the categories that are noted. The percentage of use for each service by beneficiary category and for each sponsor service will be significant in the CHAMPUS reimbursement process for BAMC under the "lead agent" concept in over-lapping catchment areas. Graph #2, p.33, illustrates the vast number of outpatient visits from the Air Force population in the BAMC catchment area. This data could be useful in future, more detailed studies of specific basic services or beneficiary categories. Graph #3, p.34, reflects the most highly utilized professional services by number of visits.

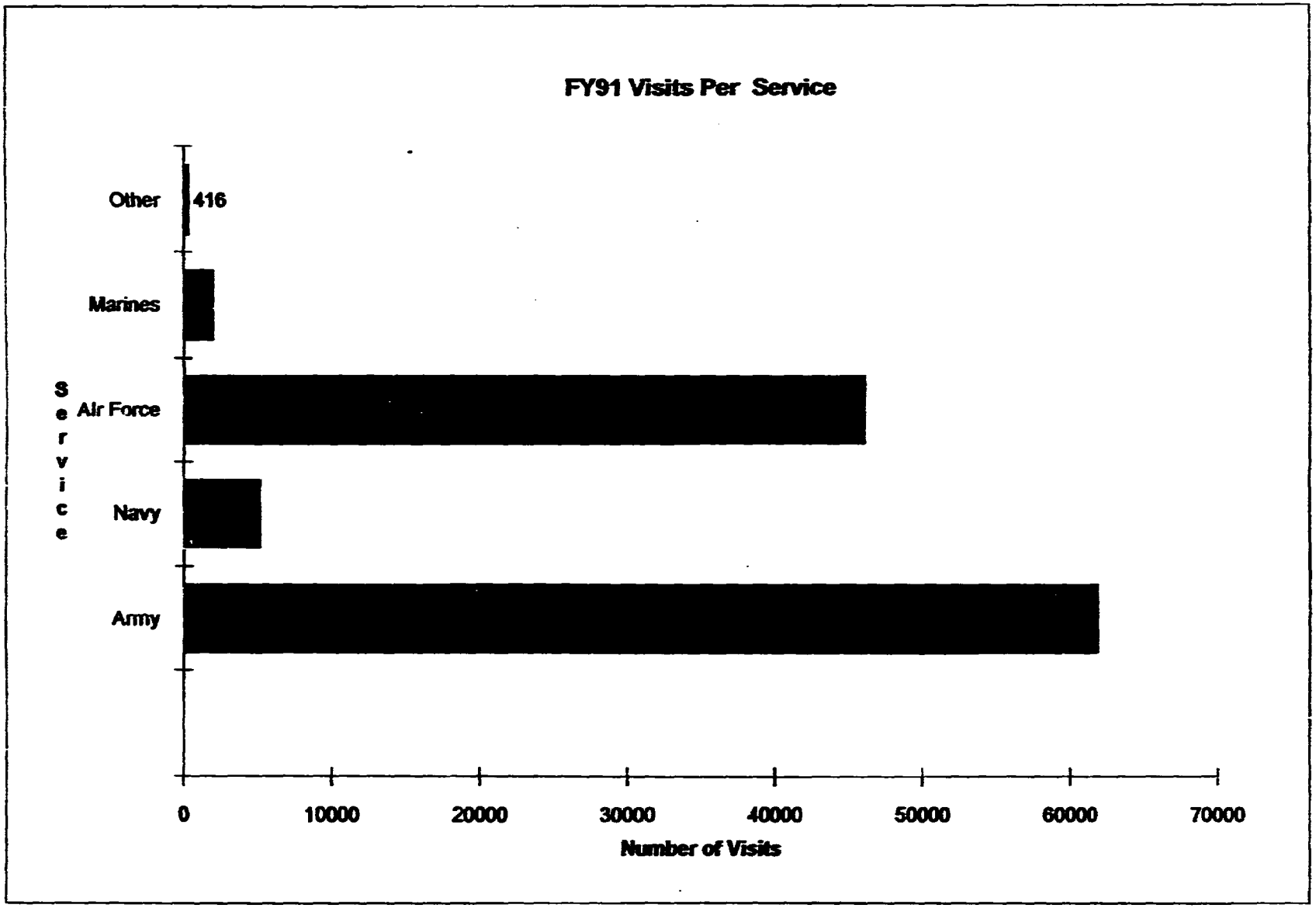
Table 3, p.35, is an illustration of the FY91 and FY 92 MEPRS Workload and Expense Totals by Psychiatric/ Mental Health Care Functional Category for BAMC. Each of the categories for each fiscal year are compared to determine increases or decreases in expenses. There are six different clinical services reviewed in this table. Graph #4, p.36, illustrates a cost comparison between FY91 and FY92 for total costs for each of these clinics. Graph #5, p.36, illustrates a comparison of FY91 to FY92 visits per clinic.

Table 4, p.37, is the FY91 MHSS CHAMPUS Outpatient Professional Services Totals by Beneficiary Category, Sponsor Service, Visits, and Ancillary Services for BAMC. It provides information on medical, surgical, radiology, pathology, and other services with the total cost to the government. The data is reviewed to determine the beneficiary category that needs to be targeted to promote costs savings.

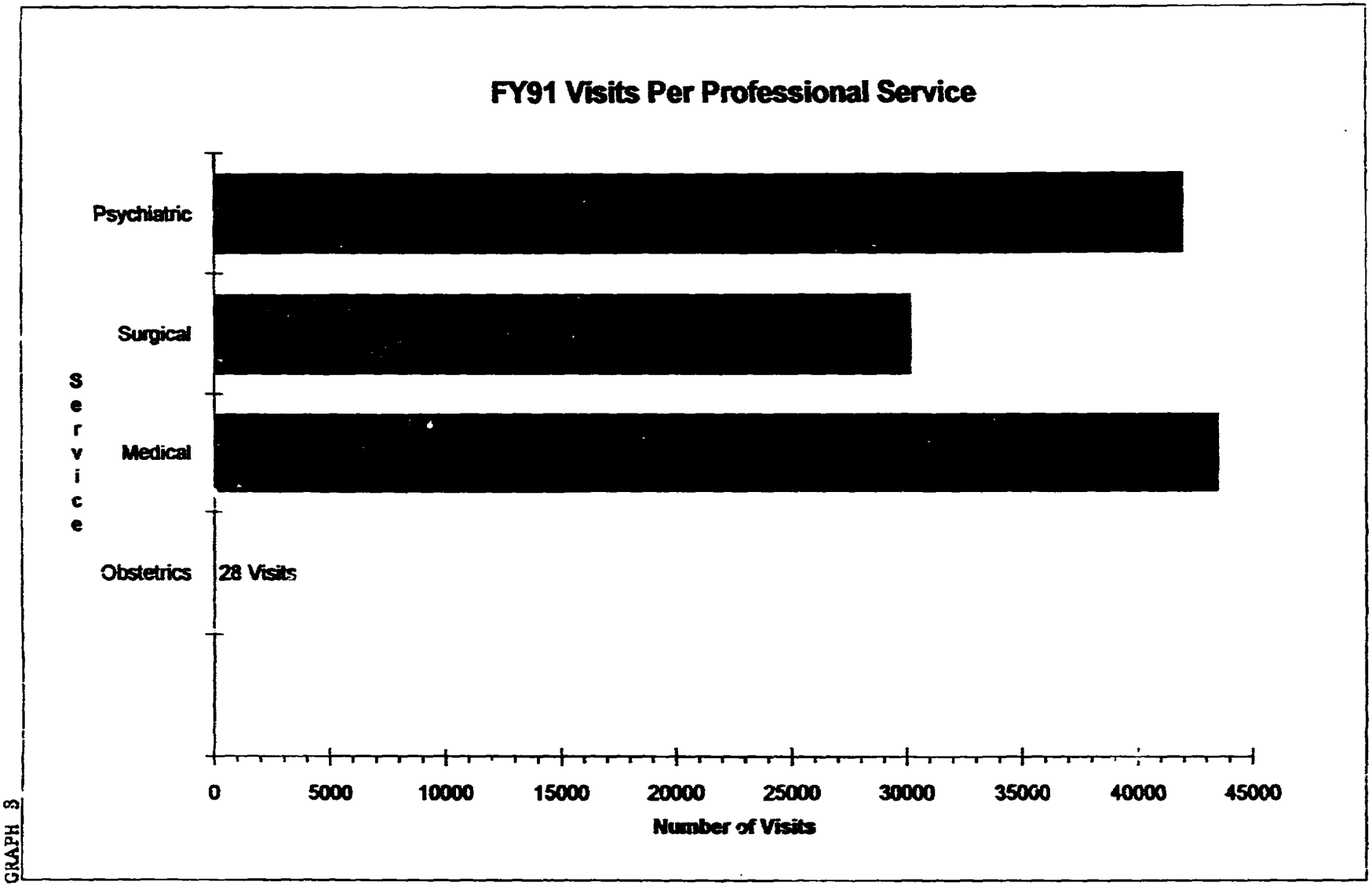
GRAPH 1

FY 91 Beneficiary Population




FY91 Visits Per Service
Other
416
Marines
Air Force
Navy
Army
Service
0
10000
20000
30000
40000
50000
60000
70000
Number of Visits

GRAPH 2


FY91 Visits Per Professional Service
Psychiatric
Surgical
Medical
Obstetrics
28 Visits
Service
0
5000
10000
15000
20000
25000
30000
35000
40000
45000
Number of Visits

GRAPH 8

TABLE 3

FY91 MEPRS WORKLOAD AND EXPENSE TOTALS
BY PSYCHIATRIC/MENTAL HEALTH CARE FUNCTIONAL CATEGORY
FOR BROOKE ARMY MEDICAL CENTER--FORT SAM HOUSTON, TX

SOURCE: DMIS INFORMATION CENTER

UCA CODE	DESCRIPTION	INPATIENT VISITS	OUTPATIENT VISITS	TOTAL VISITS	EXPENSES
BFA	PSYCHIATRIC CLINIC	522	12,038	12,560	1,258,522
BFB	PSYCHOLOGY	188	1,265	1,453	238,518
BFC	CHILD GUIDANCE CLINIC	16	715	731	174,278
BFD	MENTAL HEALTH CLINIC	0	3,523	3,523	315,023
BFE	SOCIAL WORK CLINIC	18,253	7,145	25,398	1,196,283
BFF	SUBSTANCE ABUSE REHABILITATION CLINIC	0	4,078	4,078	306,613
SUM	(Grand Totals)	18,979	28,764	47,743	3,489,237

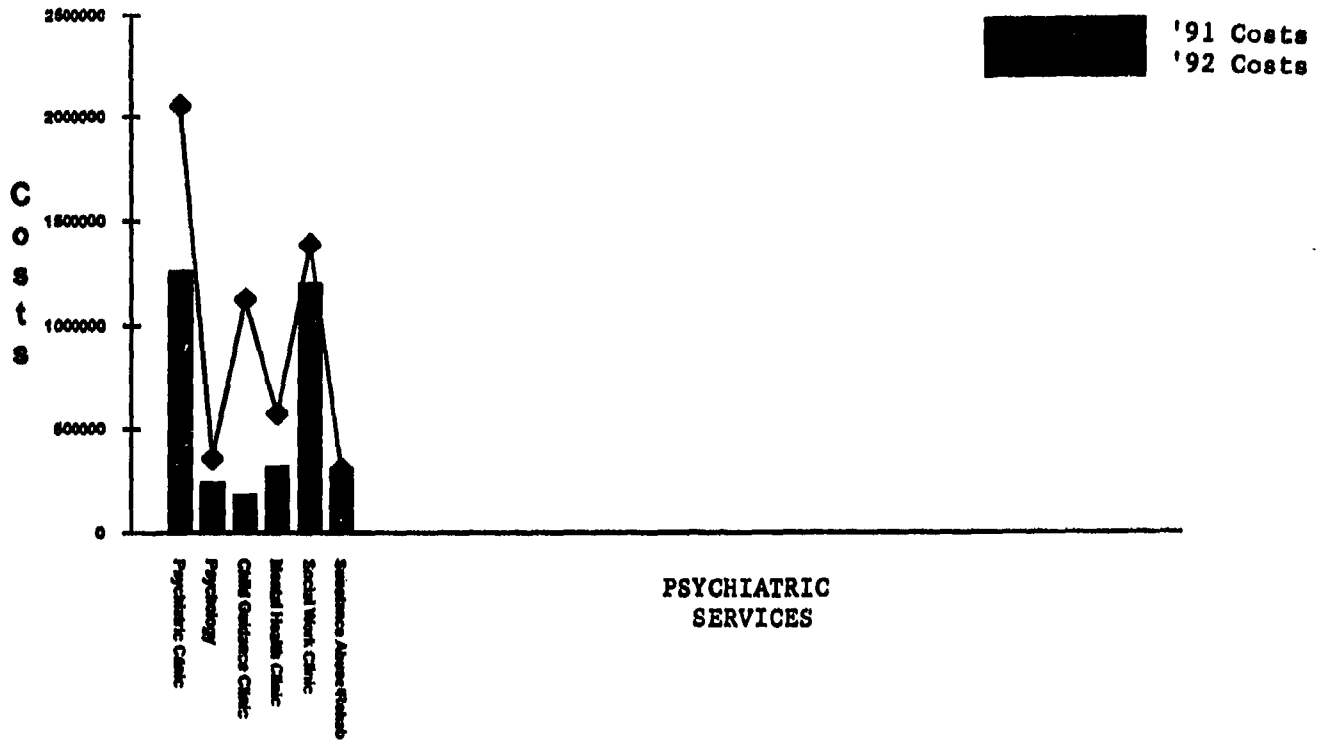
FY92 MEPRS WORKLOAD AND EXPENSE TOTALS
BY PSYCHIATRIC/MENTAL HEALTH CARE FUNCTIONAL CATEGORY
FOR BROOKE ARMY MEDICAL CENTER--FORT SAM HOUSTON, TX

UCA CODE	DESCRIPTION	INPATIENT VISITS	OUTPATIENT VISITS	TOTAL VISITS	EXPENSES
BFA	PSYCHIATRIC CLINIC	480	11,765	12,155	2,052,954
BFB	PSYCHOLOGY	129	1,514	1,643	357,616
BFC	CHILD GUIDANCE CLINIC	37	9,111	9,148	1,127,497
BFD	MENTAL HEALTH CLINIC	0	4,035	4,035	578,187
BFE	SOCIAL WORK CLINIC	31,618	9,331	40,949	1,387,350
BFF	SUBSTANCE ABUSE REHABILITATION CLINIC	0	4,078	4,078	306,613
SUM	(Grand Totals)	32,264	40,922	73,186	5,845,796

**Information provided by DMIS--19 MAY 1993

GRAPH 4

FY91/FY92 Cost Comparison for Services



GRAPH 5

FY91/FY92 Visits Comparison for Services

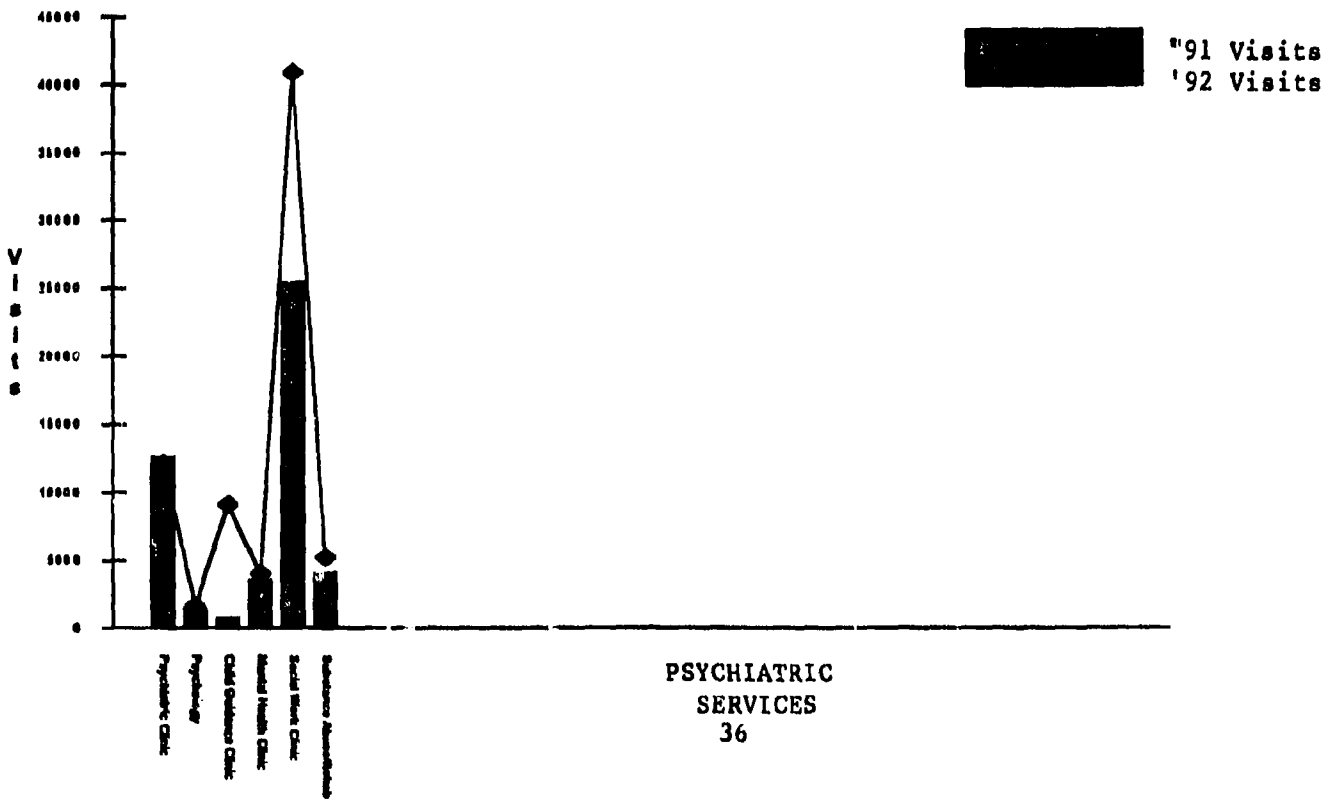


TABLE 4

19-MAY-93

FY91 MHSS CHAMPUS OUTPATIENT PROFESSIONAL SERVICES TOTALS
BY BENEFICIARY CATEGORY, SPONSOR SERVICE, VISITS AND ANCILLARY SERVICES
FOR BROOKE AMC - FT. SAM HOUSTON

SOURCE: OHIS INFORMATION CENTER

2. ANCILLARY SERVICES.

SPONSOR SERVICE	BENEFICIARY CATEGORY	MEDICAL	SURGICAL	RADIOLOGY	PATHOLOGY	OTHER	GOV COST
ARMY	DEP OF ACTIVE	4,235	858	1,003	3,934	1	2,458,585
	RETIRED	2,575	685	602	1,795	3	592,662
	DEP OF RETIRED	4,387	1,254	1,513	4,893	0	1,379,437
	SURVIVOR	637	179	186	837	0	232,706
SUB		11,834	2,976	3,317	11,459	1	4,663,390
NAVY	DEP OF ACTIVE	192	74	78	223	0	129,515
	RETIRED	325	33	130	169	0	48,537
	DEP OF RETIRED	341	105	217	606	0	147,421
	SURVIVOR	34	19	21	76	0	21,305
SUB		892	231	446	1,074	0	346,781
AIR FORCE	DEP OF ACTIVE	2,527	1,514	626	2,005	1	1,386,701
	RETIRED	1,802	704	497	1,063	0	530,821
	DEP OF RETIRED	3,037	1,189	1,170	3,831	0	985,141
	SURVIVOR	273	352	135	453	0	138,114
SUB		7,639	3,759	2,428	7,352	1	3,060,777
MARINES	DEP OF ACTIVE	99	25	17	82	0	42,366
	RETIRED	129	44	42	112	0	25,665
	DEP OF RETIRED	180	56	72	206	0	244,330
	SURVIVOR	41	4	10	26	0	6,073
SUB		449	129	161	426	0	318,414
OTHER	DEP OF ACTIVE	53	10	8	11	0	20,561
	RETIRED	1	4	7	14	0	2,488
	DEP OF RETIRED	28	10	32	53	0	16,339
SUB		82	24	47	78	0	39,388
SUB		20,896	7,119	6,399	20,389	2	8,408,750

An initial review of the grand totals for FY91 and FY 92 (table 3, p.35), indicates a substantial increase of $2,356,559 or a 167% increase for psychiatric services. Further review, using the ABC Inventory, method indicates that the first, second, and fifth ranked cost leaders (psychiatric, social work, and psychology clinics, respectively) for both years remained the same. The psychiatric clinic expenses increased 164%, while social work services had a 116% increase. The psychology clinic experienced a 150% increase in expenses. Of particular interest, is the psychiatry clinic seeing fewer patients (3% less) with a substantial cost increase, while social work increased their patient load 161%.

The third, fourth, and sixth ranked services for FY91 (mental health, substance abuse/rehabilitation, and child guidance clinics, respectively) reported the following increases: Mental health--183% increase in expenses, 114% increase in workload; substance abuse--112% increase in expenses, 129% increase in workload; child guidance--646% increase in expenses, 1,274% in workload.

An analysis of the data in table 4, p.37, revealed

that all of the sponsor services, with the exception of the Navy who used more pathology services, used more medical services than surgical, radiology or pathology. The next most frequently used service by all branches, except the Navy (medical), was pathology. The third most utilized service was radiology, except for the Air Force (surgery). Surgical services ranked last for usage except for the Air Force. A comparison with FY92 cost data for the same categories is not possible at the time, due to some CHAMPUS claims not yet being filed. A data comparison will not be available until October 1993. Army beneficiaries account for 56% of the total expenditures, followed by the Air Force with 36%, and the Navy, Marines, and other with 8%.

Of the FY91 outpatient claims which exceeded $11 million (Tables 3 & 4), psychiatric services accounted for 31% or $3,489,237 of the total expenses. Medical, surgical, radiology, and pathology were summarized by sponsor service and the cost per procedure per category could not be realistically determined.

Appendix F was analyzed to determine which clinics were the cost leaders in terms of high-cost/high-volume usage. The psychiatric clinic proved to be the number

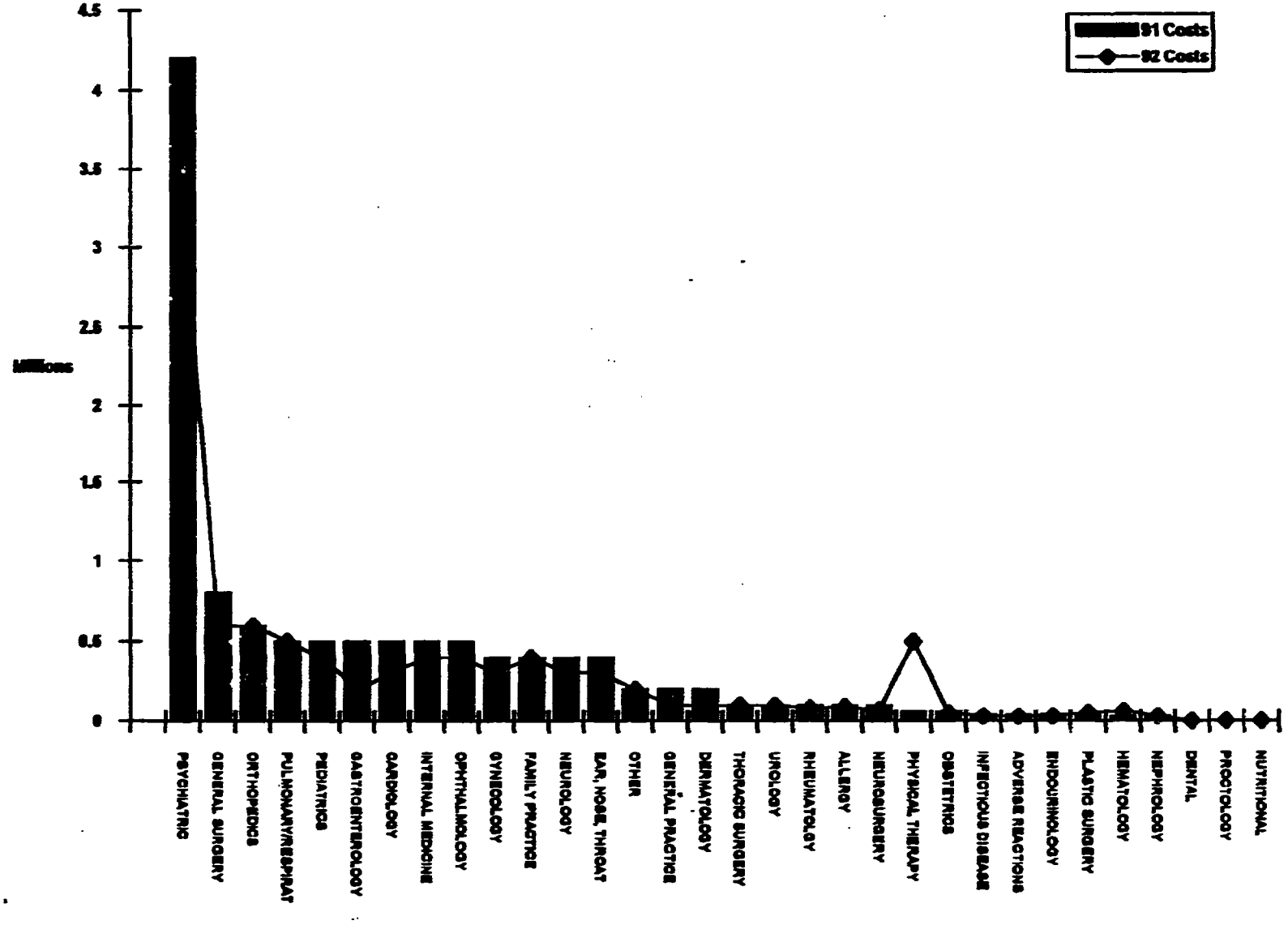
one cost leader in terms of total expenses and most utilized in terms of visits. The second and third ranked clinics (orthopedics and general surgery) showed decreases in annual expenses while increasing their workload. Ten of the remaining clinics were able to produce the same positive results, (graph #6, p.41). Only two of the categories (nephrology and other) indicated an increase in expenses while showing a decrease in workload.

The top three most expensive clinics per visit were: obstetrics-$2099; plastic surgery-$1408; and proctology-$435. These clinics reported very low visit ratios: 26, 39, and 7, respectively. Five clinics had average cost per visits that were under $40: physical therapy, $18; pediatrics, $27; allergy and family practice, $37; and internal medicine, $38. In each of these cases, the reported number of visits exceeded 9000.

A grand totals assessment, p.F-9, indicated that between FY91 and FY92 the total cost of professional services decreased by about $2.06 million or an 18% reduction. It also indicated a 112% increase in workload or total visits.

GRAPH 6

FY91 and FY92 CHAMPUS Cost Comparison Per Professional Service



The analysis of the adolescent psychiatric service revealed that the CPT-4 code, individual psychotherapy, accounted for 60% of the total expenses for that clinic during FY91. The special family therapy accounted for 20% of the total expenses. At the same time, these two procedures accounted for 82% of the total visits.

Sixteen provider specialties accounted for the entire number of visits and expenses during FY91. Four of these specialties (M.S.W., A.S.W; Marriage/Family Counselor; Psychiatry; and Psychologist) accounted for 93% of the total visits and 91% of the total expenses.

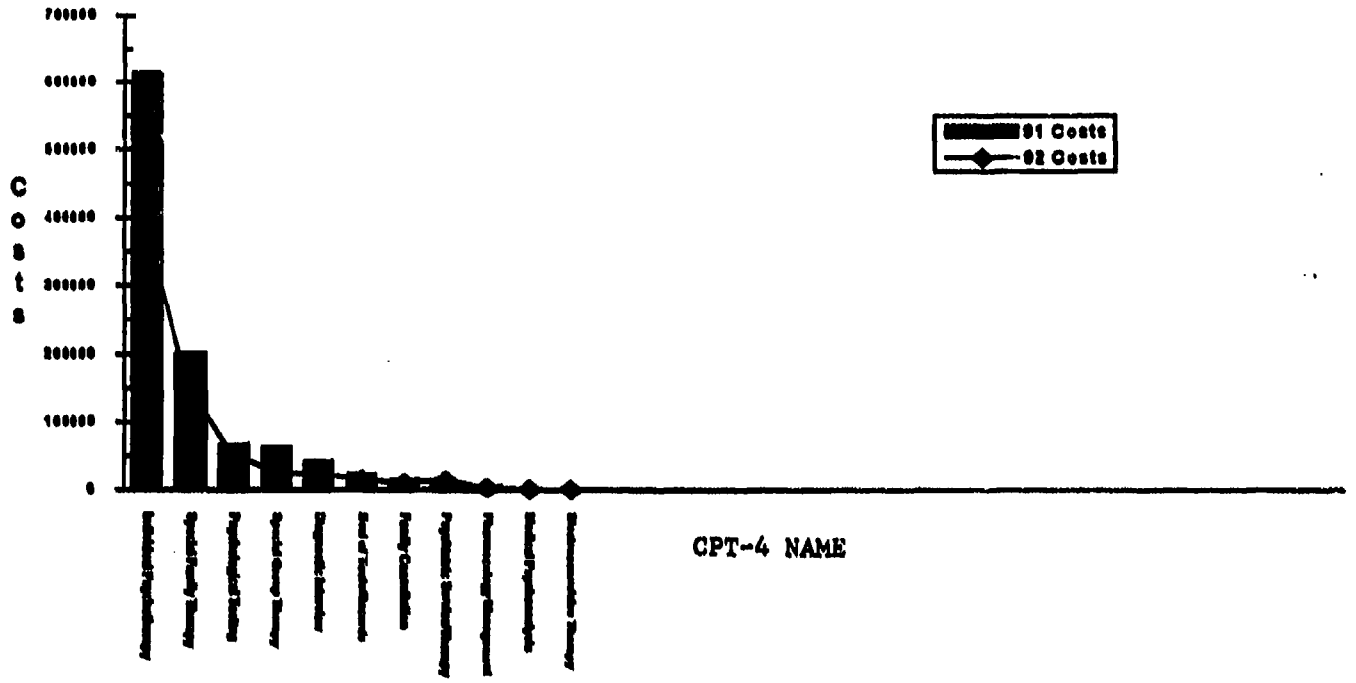
The FY 92 coding changed with the addition of an electroconvulsive therapy. This accounted for only 1 visit is therefore considered to be non-significant. Analysis of the remaining CPT-4 codes (same as FY91) revealed that individual psychotherapy and special family therapy accounted for 82% of the total visits and 79% of the total expenses.

Fourteen provider specialties accounted for all of the visits and expenses. Four provider specialties (M.S.W., A.S.W.; Mental Health Counselor; Psychiatry; and Psychologist) accounted for 94% of the total visits and 91% of the total expenses for FY92.

Psychiatric service/therapy proved to be the most expensive cost/visit procedure for FY91 and FY92. Graph #8, p.44, illustrates a cost comparison for FY91 and FY92 per CPT-4 name. Graph #8, p.44, illustrates a comparison of visits for FY91 and FY92 per CPT-4 name.

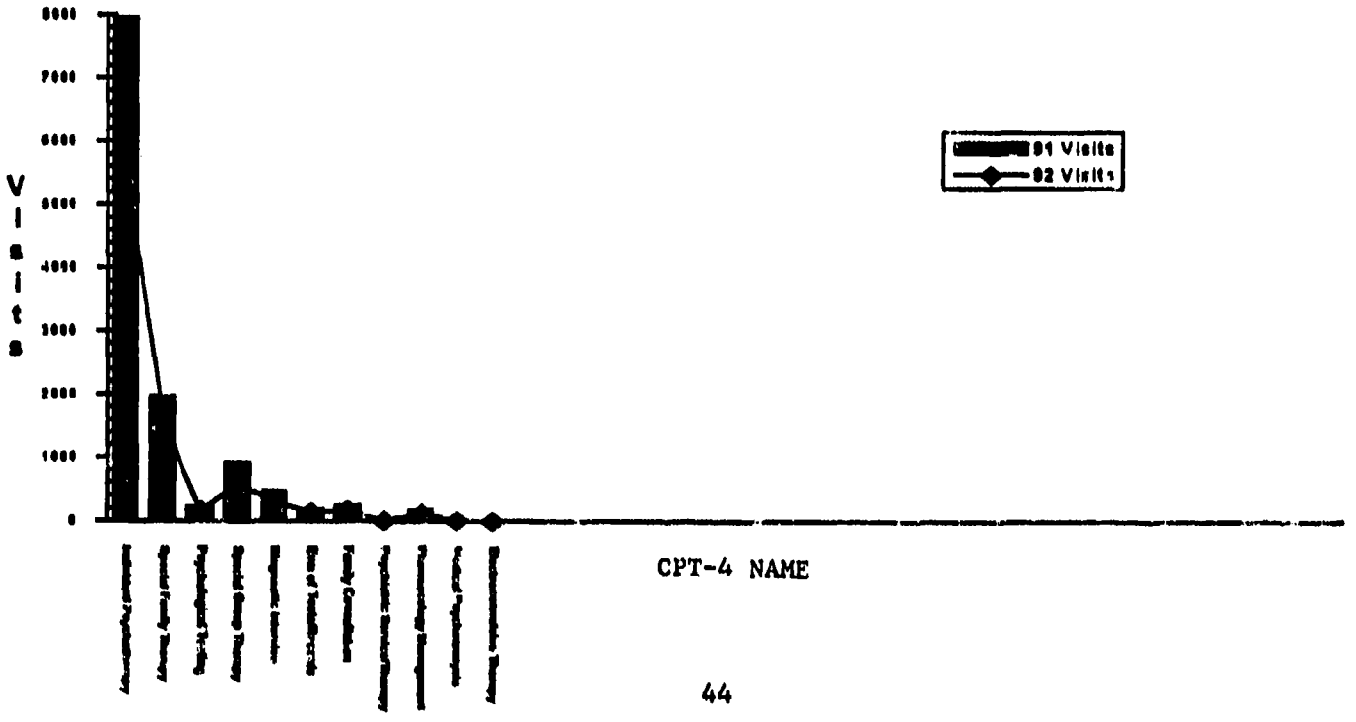
GRAPH 7

FY91/FY92 Cost Comparison Per CPT4 Name



GRAPH 8

FY91/FY92 Visits Comparison Per CPT4 Name



Discussion

The results determined by this study were not profound, but did identify some of BAMCs cost leaders in the outpatient care arena. The research of literature and deciding on a better focused project added a true sense of direction for me to follow. I rapidly discovered that sometimes too much information can be catastrophic and unmanageable.

The purpose of the project slowly blended together as the data was reviewed and analyzed. There are a few outpatient areas that we need to give more emphasis in terms of contract management and cost containment. The investigation proved that we could develop a marketing niche to recapture some of the high-cost/high-volume user population. This was demonstrated by several of the clinical settings decreasing their overall expenses for professional services and increasing the number of available appointments. This is indicative of the results that are expected under the Gateway to Care program.

Visits, costs, and types of services were the focal points for this paper, as they are the essential elements to be reviewed in order to gain control or to

recapture the CHAMPUS outpatient population. The literature supports several of the principal ideas that were investigated. In particular, contract management and utilization management are strongpoints of operating a business. The future of military healthcare will depend strongly upon our ability to run our MTFs as a professional business.

The intense background information is essential because it provides one view of the kaleidoscopic healthcare environment that is found in the SAMCSA. It also provides a basis for understanding the complexity of the community that needs to be recaptured as a part of BAMC marketing plan. Identifying the cost leaders by beneficiary category, sponsor service, or by usage will allow the coordinated care division to emphasize and prioritize various parts of the enrollment process.

Eventually, the CCD should be able to identify, by name, the principal individuals who represent the 31% of the eligible users who are spending in excess of $11 million dollars for outpatient CHAMPUS treatment. These individuals in-turn become the focus of our managed care outpatient marketing program.

Review of the FY91/92 MEPRS Workload and Expense

Totals for psychiatric care allows us rapidly identify those areas that appear to be expanding at an abnormal rate (i.e. child guidance clinic) and conduct an internal analysis to determine the causes of the growth and extreme increase in the number of visits. The analysis also sets the stage to assess our needs based upon the present contract. Psychiatry has presented its own share of problems to the military healthcare system for years; and after several stringent reviews, most programs were able to reduce their expenses.

The review of the ancillary services data can assist us in determining future needs for equipment and space utilization. It also provides a tracking mechanism to conduct trend analyses. We could readily discern that the primary users are dependents of active duty and dependents of retirees. We were also able to determine the services that were being utilized most frequently. This report did not investigate the personnel or equipment needs to recapture part of the using population, but rather identified them as targets for future marketing efforts.

The ability to observe the statistics on the number of visits and the costs for the thirty-two

clinical settings further supports our ability to more accurately manage the resources in those areas. It was evident that the cost leaders by volume did not necessarily coincide with the cost leaders by annual professional services costs. It was also apparent that a true cost per visit/procedure is not available. The institution of ambulatory patient groups (APGs) for outpatient treatments may allow facilities, third party payors, and patients to gain control of this dimension of healthcare.

Conclusions and Recommendations

The survival of MTFs in the future will greatly depend upon our ability to capture data on every facet of our operation. More importantly, however, will be our ability to accurately analyze the data and make sound decisions based upon our findings.

In this case, psychiatric services along with several other areas were identified as having high-cost/high-volume expenses. Just as the initial report on the psychiatry contract (Beers, 1992) revealed some discrepancies, we must continue to make such contracts the object of our utmost scrutiny.

This research provided a finite observation of a

very thin vein of the hospital's budget and did not investigate any of the specific areas for possible solutions to their high-cost/high-volume usage. Each of the areas identified as high-cost/high-volume have the potential to reap even greater savings through more investigation. The results of this study could be used by the Chief of Staff as a primary targeting mechanism for the clinical areas to determine new methods for increasing appointments, operating more efficiently, or cost-shifting insured patients to the civilian community, in that there is not a current mechanism to recapture outpatient expenditures.

This is definitely an area that is open for further investigation and monitoring. The recent paradigm of shifting care from inpatient to outpatient presents a strong basis for more observation of the expenses of providing such care. The ability to work smarter and not harder in the outpatient arena may also provide the impetus for patients to shift their usage patterns from the emergency room to the clinical setting.

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GLOSSARY

beneficiary--anyone who is eligible for care at a MTF.

catchment area--the area contained within a 40 mile radius of the MTF.

coordinated care/managed care--these terms are used interchangeably and refer to the MTF managing and directing the correct regimen of care for its beneficiary population.

enrollment--the process of entering a beneficiary into the Gateway to Care

"in-house"--providing care within the MTF

recapture--to gain control over a segment of the population and provide treatment "in-house" as opposed to allowing them to be treated elsewhere.

registration--the process of identifying the eligible population and consolidating information about the beneficiary population. This process does not guarantee care at the MTF.

visit--a patient/provider encounter that involves an epidsode of care.

ABBRNVIATIONS

AFB--Air Force Base
BAMC--Brooke Army Medical Center
CCP--Coordinated Care Plan
CHAMPUS--Civilian Health and Medical Program of the Uniformed Services
DEERS--Defense Enrollment/Eligibility Reporting System
DMIS--Defense Medical Information System
DoD--Department of Defense
GME--Graduate Medical Education
GTC--Gateway to Care
HCFA--Health Care Financing Administration
HMO--Health Maintenance Organization
HSC--Health Services Command
MHSS--Military Health Services System
MTF--Medical Treatment Facilities
OASD[HA]--Office of the Assistant Secretary of Defense for Health Affairs
OTSG--Office of the Surgeon General
PAO--Public Affairs Officer
POS--Point-of-Service
RAPS--Resource Analysis and Planning System
SAMCSA--San Antonio Military Community Service Area
WHMC--Wilford Hall Medical Center

LIST OF TABLES

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APPENDIX A

"DOOMSDAY LETTER"

FISCAL YEAR 1994 BUDGET DECREMENT

DEPARTMENT OF THE ARMY
HEADQUARTERS, UNITED STATES ARMY HEALTH SERVICES COMMAND
FORT SAM HOUSTON, TEXAS 78234-6000

REPLY TO
ATTENTION OF

HSRM-M (1-1b)

08 APR. 1993

MEMORANDUM FOR HSC MEDCENs/MEDDACs

SUBJECT: Fiscal Year 1994 Budget Decrement

1. Reference memorandum, HQ HSC, HSRM-P, 11 February 1993, subject: Fiscal Year (FY) 1994 Initial Operation and Maintenance, Defense (OMD) Funding Guidance.

2. I recently received an apropos memorandum from The Surgeon General that necessitates our immediate attention and action (Enclosure 1). You are well aware of the budgetary and personnel reductions from my previous correspondence on 11 February 1993. This command will forward to you approved guidance based upon the action plan you submitted.

3. The reduction of approximately 900 physicians by the end of FY 95, offers me no other choice but to target the larger medical treatment facilities (MTFs) for these reductions. In candor, I must state that reductions of this size cannot be assessed without cutting into our graduate medical education (GME) programs. Currently, Colonel Cassimatas, Chief, GME Branch, Office of The Surgeon General, and Colonel Gonzalez, Deputy Chief of Staff for Clinical Services, U.S. Army Health Services Command have established a process action team (PAT) to evaluate all aspects of the GME program.

4. I have two immediate concerns. First, your FY 94 budget action plan provides a general description of your direction, but lacked the specificity required by Department of Defense (DOD). Upon receipt of your approved plan you will submit to us your detailed plan in accordance with DOD Instructions (DODI 6015.20) (Enclosure 2) no later than 1 June 1993.

5. Secondly, the beneficiary must remain our focus. I want you to begin marketing your plan for FY 94, through a variety of media, to your beneficiaries immediately so to minimize their concerns and fears. Please provide me with feedback from your customers by the first of each month beginning 1 May 1993.

2 Encls

RICHARD D. CAMERON
Major General, MC
Commanding

DEPARTMENT OF THE ARMY
OFFICE OF THE SURGEON GENERAL
5109 LEESBURG PIKE
FALLS CHURCH, VA 22041-3258

REPLY TO ATTENTION OF

06 APR 1993

DASG

Major General Richard D. Cameron
Commander
U.S. Army Health Services Command
Fort Sam Houston, TX 78234-6000

Dear General Cameron,

I am writing to let you know some alarming developments that will have a profound impact on the Army Medical Department's future ability to provide quality health care both in war and in peace. Our system, with its three pillars of combat health care, individual health care and community health care, is facing a reduction in funding and personnel that will touch everyone, especially our most valued asset, our patients.

In your position, you are more than aware of the accelerated reductions in military strength, the closing or reshaping of bases here and abroad and the effects of these reductions on mission accomplishment. While our directed share of these strength reductions is 16%, our workload only declines by about 10%. Although we've been given the authority to hire nearly 2,000 civilians, we don't have the money to pay them. Add to this a budget shortfall for FY94 that is more than $200-million and we have a prescription for potential failure.

Included in our personnel reduction is the loss of 900 physicians, which not only impacts on our Graduate Medical Education program (the lifeblood of our physician recruiting and retention efforts) but results in 900 physicians who won't be there when our patients need the quality care and treatment they've earned and deserve.

Having been in your shoes, I know you are facing some drastic decisions to meet these reductions - possibly reducing some medical centers to medical activities by curtailing clinical services and closing and consolidating wards, reducing some of our smaller hospitals to clinics and even closing some activities and restricting the provision of some services to the absolute bare minimum.

Be advised that Public Law 101-510, Section 716, requires Congressional notification of any reduction of medical services. I fully intend to comply with that law and to that end I will require you to detail your plans for any reductions ASAP.

I know you share my concern for our beneficiaries and that you will make every effort to minimize the impact the future will have on them. Do your best and be assured that I will be making as strong a case as possible with those who can make a difference.

Sincerely,

Alcide M. LaNoue
Lieutenant General
The Surgeon General

Department of Defense

INSTRUCTION

December 3, 1992
NUMBER 6015.20

ASD(HA)

SUBJECT: Changes in Services Provided at Military Medical Treatment Facilities (MTFs) and Dental Treatment Facilities (DTFs)

References: (a) DoD Instruction 6015.20, "Changes in Services Provided at Military Medical Treatment Facilities (MTFs)," June 23, 1987 (hereby canceled)
(b) Section 715 of Public Law 101-510, "The National Defense Authorization Act for Fiscal Year 1991," November 5, 1990
(c) Section 8070 of Public Law 102-172, "The Department of Defense Appropriations Act for Fiscal Year 1992," November 26, 1991

A. REISSUANCE AND PURPOSE

This Instruction reissues reference (a) to update policy, responsibilities, and procedures for reporting major changes in services provided at the MTFs and the DTFs, to the Office of the Assistant Secretary of Defense (Health Affairs), under references (b) and (c).

B. APPLICABILITY AND SCOPE

This Instruction applies to:

1. The Office of the Secretary of Defense (OSD), the Military Departments, the Chairman of the Joint Chiefs of Staff and the Joint Staff, and the Defense Agencies concerned with military healthcare (hereafter referred to collectively as "the DoD Components").

2. The MTFs and the DTFs worldwide.

C. DEFINITIONS

Terms used in this Instruction are defined in enclosure 1.

D. POLICY

It is DoD policy that any major change in service provided at an MTF or a DTF shall be reported to the Assistant Secretary of Defense (Health Affairs).

E. RESPONSIBILITIES

1. The Assistant Secretary of Defense (Health Affairs) (ASD(HA)) shall:

a. Monitor compliance with this Instruction.

b. Disseminate information on reported changes to the DoD components, after ASD(HA) approval, but before the Congress is notified.

c. Report approval/disapproval decision to Service Secretaries.

2. The Secretaries of the Military Departments shall prepare implementing guidance and ensure compliance with this Instruction in their Departments, the MTFs, and the DTFs.

F. PROCEDURES

1. Any major change in service provided at an MTF or a DTF, as described in enclosure 1, subsections 1.b.(1) through 1.b.(4), shall be reported through the Military Department chain-of-command, and the Deputy Assistant Secretary of Defense (Health Services Operations) (DASD(HSO)), to the ASD(HA) for approval, not less than 60 days before the change is scheduled.

2. Any MTF or DTF closure or reduction in the level of care, as described in enclosure 1, subsections 1.b.(5) and 1.b.(6), shall be reported through the Military Department chain-of-command and the DASD(HSO), to the ASD(HA) for approval 120 days before the action is scheduled. After he approves it, but no later than 90 days before the action is scheduled, the ASD(HA) shall forward the report to the Congress, as required by Pub. L. No. 101-510, Section 716 and Pub. L. No. 102-172, Section 8070 (references (b) and (c)). There is one exception, as shown in subsection D.3., below.

3. When an MTF or a DTF reduces the level of care as the result of a base realignment and closure (BRAC), the facility shall publish a healthcare delivery transition plan to accommodate beneficiaries during the change period. The plan must be forwarded through the Military Department chain-of-command, and the DASD(HSO), to the ASD(HA) as soon as it is finalized, but not less than 120 days before the first service is scheduled to close at the facility. Annual updates shall be required, not later than 60 days following the end of each fiscal year (FY), to indicate which services were actually phased out during that FY. The annual reporting requirement is terminated when the final service is closed.

4. Changes in services which are made under the following circumstances do not require ASD(HA) approval, however, they shall be promptly reported through the Military Department chain-of-command to the ASD(HA):

a. A facility rendered structurally unsound by a natural disaster.

b. An initial response to an emergency deployment of medical personnel, such as Operation DESERT SHIELD.

c. A change in a Status of Forces Agreement, such as the one by which the Subic Naval Hospital was closed.

G. INFORMATION REQUIREMENTS

The notification of a change at an MTF or a DTF shall contain the information included at enclosure 2. The reporting requirement, in section F, has been assigned Report Control Symbol DD-HA(AR)1776.

H. EFFECTIVE DATE AND IMPLEMENTATION

This Instruction is effective immediately. Forward one copy of implementing documents to the Assistant Secretary of Defense (Health Affairs) within 120 days.

Enrique Mendez, Jr., M.D.

Enclosures - 2
1. Definitions
2. Information to be reported to the ASD(HA)

DEFINITIONS

1. A Major Change. A change that shall do the following:

a. For a period of 6 months or more, change the current volume of care provided to one or more categories of beneficiaries at an MTF or a DTF, by any medical specialty, dental specialty, ancillary service, or satellite clinic, by 10 percent or more at large facilities (over 250 beds) to 50 percent or more at small facilities (0 to 50 beds).

b. Have an impact on users that may stimulate local public or congressional objections. Such changes include the following:

(1) Opening or reinstating services.

(2) Increasing facility capability in one or more services through staffing reassignments, provider productivity changes, facility repairs or renovations, nursing unit closings, equipment breakdowns or acquisitions, supply shortages, contracting, or the implementation of sharing agreements of the Department of Veterans Affairs.

(3) Decreasing facility capability in one or more services by the means in subdefinition 1.b.(2) above (for 90 days or more, or for an indefinite period).

(4) Temporarily closing services (for 90 days or more, or for an indefinite period).

(5) Permanently closing services.

(6) Closing a facility.

2. Dental Treatment Facility. A clinic, operated by one of the military services, which provides outpatient dental care that may include a wide range of specialized and consultative support.

3. Medical Treatment Facility (MTF). A facility, operated by one of the military services, which provides inpatient and outpatient medical and dental care to eligible individuals.

INFORMATION TO BE REPORTED TO THE ASD(HA)

FOR A MAJOR AND NON-BRAC RELATED CHANGE IN SERVICES, the following information must be reported to the ASD(HA) through the appropriate chain-of-command:

A. Name and location of the MTF or the DTF.

B. Type of change, where appropriate by the Medical Expense and Performance Reporting System (MEPRS) specialty area.

C. Effective date of change, where appropriate by the MEPRS specialty area.

D. The reason for the change.

E. The estimated workload changes, where appropriate by the MEPRS specialty area, in the number of outpatient visits, admissions, occupied bed days, or ancillary service units and, when applicable, by category of beneficiary.

F. The projected savings to the Government from the change, both in military and civilian staff and funds, by fiscal year.

G. The impact on the Civilian Health and Medical Program of the Uniformed Services and MEDICARE costs in the facility's catchment area.

H. The net resources resulting from the proposed change.

I. The impact on beneficiary cost-sharing.

J. An explanation of the alternative ways to provide care to the persons served by the facility (that will not result in adverse consequences to such persons).

K. An identification of the alternative selected and the cost, if any, to those persons to receive such care.

APPENDIX B

LETTER FROM CG TO BENEFICIARIES

What Does Coordinated Care Mean to San Antonio?

Beneficiaries will continue to receive the best quality medical care available. We are committed to maintain the highest level of quality care for all of your health care needs as one of our beneficiaries.

Accessibility to the health care provider will be increased through the establishment of Primary Care Case Managers. These health care providers will assist you, the patient, in making any needed specialty clinic appointments. No more busy signals on the telephone!

Managing our future assets more effectively will allow BAMC to participate in innovative programs, such as the "Preferred Provider Network" and the "CHAMPUS Partnership Program." This will allow us to offer you better, faster and more convenient service at "no or reduced" CHAMPUS copayment.

Commitment on our part to continue to strive to be on the forefront of future military and civilian medical care will be the driving force to ensure a bright future for our beneficiaries and BAMC alike.

Please take a moment to read the content of the enclosed information and find out how BAMC's Gateway to Care Program can benefit you and your family!

APPENDIX C

GATEWAY TO CARE:

MARKETING/PUBLIC AFFAIRS PLAN (DRAFT)

GATEWAY TO CARE - MARKETING/PUBLIC AFFAIRS PLAN

BROOKE ARMY MEDICAL CENTER

1. PURPOSE. To educate target beneficiaries and encourage them to enroll in the Gateway to Care program at Brooke Army Medical Center.

2. SITUATION. Gateway to Care offers beneficiaries improved access to care, better care and reduced costs. However, as designed, it limits choice of providers so some beneficiaries may be reluctant to sign up. Since Gateway to Care can fulfill its potential only with near-maximum participation in targeted specialties, an education campaign is necessary to overcome this reluctance. Growth of the program at BAMC will be through phased voluntary enrollment beginning with the lower grade enlisted personnel and their families.

3. CONCEPT. BAMC will rely on briefings, staff contacts with patients, direct mail and "hand outs." Mass media exposure will be limited because of the phased enrollment plan, however, routine releases will be made to command information media such as the post newspaper. Civilian media publicity will be in response to inquiries only except where proactive approaches are deemed appropriate.

4. PARTICIPANTS.

a. Commander, Deputy Commander for Clinical Services, BAMC.

b. Chief, Coordinated Care Office, BAMC.

c. Public Affairs Office, BAMC.

5. COMMUNICATION CHANNELS.

a. Multifold brochures. BAMC has an initial stock of 30,000 of the brochures which discuss in generic terms the Gateway to Care program. These will be used in a variety of ways to generate knowledge and acceptance of the GTC.

b. Full-color posters. BAMC has 150 in stock. These will be posted in high traffic areas such as the post exchange, commissary, officers and NCO clubs, building lobbies. Primary purpose of the posters is to publicize the program's title -- Gateway to Care -- and to make it an easily recognizable name. No other words should be employed since Gateway to Care is universal and it could be confusing to beneficiaries.

c. Gateway to Care BAMC kit. A kit will be prepared tailored to BAMC's program and should include as a minimum:

(1) Fact sheet with questions and answers concerning the BAMC program.

(2) Enrollment form with instructions if necessary.

(3) Selected articles about GTC.

(4) Specialty items such as information slide, magnet, etc.

d. Post/base newspapers.

(1) Fort Sam Houston.News Leader. Articles announcing Gateway to Care enrollment and appropriate information should be submitted for publication in the 18 and 25 September 1992 issues. Articles should mention how the program will affect retirees and their families.

(2) Base newspapers. Weekly newspaper published at Randolph Air Force Base should be utilized when appropriate to reach those retired beneficiaries who reside within the circulation area of that newspaper.

e. Briefings.

(1) The BAMC Commander or, if appropriate, a designated representative should brief the Commanders, Fifth U.S. Army and Fort Sam Houston; AMEDD Center and School, US Army Health Services Command, Fort Sam Houston Garrison, Fifth Recruiting Brigade and other units whose personnel receive primary care at BAMC.

(2) The BAMC commander and other senior staff members should include Gateway to Care information whenever speaking before internal publics especially retiree groups/organizations.

f. Retiree Open house. A retiree open house is scheduled at Fort Sam Houston on 3 October 1992. The CCO should consider manning a booth there with appropriate information available to distribute to retirees. These could include the GTC brochures and a fact sheet outlining the BAMC program. The CG and DCCS are scheduled to speak at the open house and should mention GTC.

g. Post orientation. The PAO has a table at the monthly Fort Sam Houston newly assigned personnel orientation program at the Road Runner Recreation Center. Information materials such as the GTC brochure and the BAMC information fact sheet and/or slides will be made available there for newly arrived soldiers and their families.

6. Execution.

a. Commander, BAMC.

(1) Brief Fifth US Army and Fort Sam Houston commander and staff enlisting their support for the program.

(2) Ensure entire staff is briefed and periodically updated on GTC implementation. Commander/command group make presentations, as appropriate, to such organizations as retiree groups, spouse clubs, etc.

b. Coordinated Care Office, BAMC.

(a) Provide information to PAO and other offices and review PAO products for accuracy.

(b) Ensure direct mail distribution of fliers/brochures/fact sheets, place them in racks and other suitable "take one" sites in high traffic areas and display posters on bulleting boards.

c. Public Affairs Office, BAMC.

(1) Assist the CCO whenever appropriate to produce GTC materials.

(2) Prepare and disseminate news releases to the Fort Sam Houston Newsleader. and other media deemed appropriate.

(3) Serve as spokesperson for BAMC in replying to news media inquiries about GTC.

APPENDIX D

FY91 DMIS POPULATION DATA REPORT

BROOKE ARMY MEDICAL CENTER
FY 91 Population Data Information

GENDER	AGE	A.D.	NG/RC	AD DEP	RC DEP	RETIREE	RET DEP	OTHER	TOTAL
Female	0-4	0	0	1,910	134	0	177	9	2,230
	5-14	0	0	3,965	332	0	1,544	101	5,942
	15-17	0	0	935	95	0	1,028	68	2,126
	18-24	1,008	104	2,250	179	1	1,801	138	5,481
	25-34	1,438	108	3,505	213	32	436	58	5,790
	35-44	836	72	2,736	231	126	2,510	167	6,678
	45-64	80	17	688	101	224	9,760	1,322	12,192
	65+	0	0	61	0	242	4,556	2,970	7,829
Male	0-4	0	0	2,086	119	0	165	10	2,380
	5-14	0	0	4,256	345	0	1,524	96	6,222
	15-17	0	0	1,012	109	0	1,104	73	2,298
	18-24	2,967	336	825	90	28	1,745	124	6,115
	25-34	4,621	267	341	27	156	74	19	5,505
	35-44	3,904	300	226	26	1,826	44	16	6,342
	45-64	844	147	97	12	11,255	28	7	12,390
	65+	0	0	17	0	6,331	33	9	6,390
		15,698	1,351	24,912	2,013	20,221	26,529	5,186	95,910

WILFORD HALL MEDICAL CENTER
FY 91 Population Data Report

GENDER	AGE	A.D.	NG/RC	AD DEP	RC DEP	RETIREE	RET DEP	OTHER	TOTAL	
Female	0-4	0	0	2,160	80	0	116	11	2,367	2.91%
	5-14	0	0	3,825	222	0	1,304	65	5,416	6.65%
	15-17	0	0	742	51	0	862	43	1,698	2.09%
	18-24	1,041	33	1,931	69	1	1,570	111	4,756	5.84%
	25-34	1,349	70	3,547	179	28	324	50	5,547	6.81%
	35-44	622	34	2,318	145	76	2,059	95	5,349	6.57%
	45-64	80	2	485	50	202	8,785	1,033	10,607	13.03%
	65+	0	0	46	0	92	3,398	1,804	5,340	6.56%
Male	0-4	0	0	2,174	89	0	160	17	2,440	3.00%
	5-14	0	0	3,957	177	0	1,291	78	5,504	6.76%
	15-17	0	0	750	39	0	875	40	1,704	2.09%
	18-24	2,799	118	613	57	17	1,440	82	5,126	6.30%
	25-34	4,473	280	343	20	84	52	8	5,280	6.49%
	35-44	2,898	204	212	9	1,408	33	5	4,771	5.86%
	45-64	459	108	87	4	10,093	28	5	10,783	13.25%
	65+	0	0	15	0	4,680	23	1	4,719	5.80%
		13,692	880	23,205	1,191	16,692	22,318	3,449	81,407	100.00%

F=Female
M=Male

APPENDIX E

BAMC CATCHMENT AREA INFORMATION (COMPOSITE)

BROOKE ARMY MEDICAL CENTER
FORT SAM HOUSTON
SAN ANTONIO, TEXAS
Catchment Area 109*

Beneficiary Population - 91,774	
Active Duty Military -	14,237
Dependents - Active Duty -	24,774
Reserve Components -	852
Dependents - Reserve Component -	1,305
Retirees -	19,545
Dependents - Retirees -	26,091

Medical Center
500 Inpatient Beds
Medical and Surgical Specialties and Sub-Specialties
Tertiary Care

CHAMPUS-Eligible Population - 63,855	
Dependents - Active Duty -	25,564
Dependents - Reserve Component -	1,302
Retirees -	13,342
Dependents - Retirees -	22,132
Survivors and Others -	2,515

CHAMPUS Admissions - 778	
Dependents - Active Duty -	355
Retirees -	95
Dependents -	328

CHAMPUS Outpatient Visits - 79,280	
Dependents - Active Duty -	39,236
Retirees -	8,891
Dependents - Retirees -	31,153

CHAMPUS HEALTH CARE SUMMARY*

Total CHAMPUS Care	
User Beneficiaries -	28,566
Total Payments -	$33,792,474
Inpatient Services	
User Beneficiaries -	1,760
Total Payments -	$22,549,696
Inpatient Hospital Services	
User Beneficiaries -	872
Admissions -	1,037
Total Payments -	$19,403,218

*Information provided by COL Barabara Ramsey (SEP 92), Coordinated Care Division, BAMC. Reproduced July 93.
**Detailed data available - by Primary Diagnosis, Beneficiary Category, Visits, Cost Detail, Admission

Catchment Area 109 Information Continued

Inpatient Professional Services	
User Beneficiaries -	1,631
Number of Visits -	22,975
Total Payments -	$3,146,478
Outpatient Professional Services	
User Beneficiaries -	28,158
Number of Visits -	115,156
Total Payments -	$11,236,695

*Detailed Data Available - By Primary Diagnosis, Category of Beneficiary, Visits, Cost Detail, Admission

APPENDIX F

FY91/FY92 COST SUMMARY

FOR

INSTITUTIONAL AND PROFESSIONAL SERVICES

U.S. ARMY GATEWAY TO CARE
COST SUMMARY INSTITUTIONAL & PROFESSIONAL SERVICES COSTS
FOR CARE END DATES OF 9010-9109 & 9110-9209
WHERE FISCAL YEAR 1991 = 9010-9109 / 1992 = 9110-9209

FACILITY BROOKE AMC FT SAM HOUSTON

		TOTAL PAID*INST+PROF SVC	TOTAL PAID*INSTITUTION	OT PD*PROF SVCS	ADMISSIONS	TOTAL*BED DAYS	TOTAL*PROF SVCS	TOTAL*VISITS
CLINICAL CATEGORY:	IDX:FY-CARE END DATE							
ADVERSE REACTIONS	1991	-42239.42	0.00	-42239.42	0.00	0.00	-1329.00	-193.00
	1992	29716.24	0.00	29716.24	0.00	0.00	885.00	123.00
	DIFF	-12523.18	0.00	-12523.18	0.00	0.00	-444.00	-70.00
ALLERGY	IDX:FY-CARE END DATE							
	1991	-105367.12	0.00	-105367.12	0.00	0.00	-6303.00	-2245.00
	1992	93356.95	0.00	93356.95	0.00	0.00	16466.00	2521.00
	DIFF	-12010.17	0.00	-12010.17	0.00	0.00	10163.00	276.00
CARDIOLOGY	IDX:FY-CARE END DATE							
	1991	-462378.26	0.00	-462378.26	0.00	0.00	-6727.00	-1240.00
	1992	292111.56	0.00	292111.56	0.00	0.00	5412.00	1336.00
	DIFF	-170266.70	0.00	-170266.70	0.00	0.00	-1315.00	96.00
DENTAL	IDX:FY-CARE END DATE							
	1991	-5411.82	0.00	-5411.82	0.00	0.00	-114.00	-41.00
	1992	4160.65	0.00	4160.65	0.00	0.00	51.00	23.00
	DIFF	-1251.17	0.00	-1251.17	0.00	0.00	-63.00	-18.00

(CONTINUED)

SOURCE: TRI-SERVICE CHAMPUS STATISTICAL DATABASE
FINANCIAL ANALYSIS SUPPORT SYSTEM (FASS)
U.S. ARMY HEALTH CARE STUDIES
FT. SAM HOUSTON, TX 78234-6000

* PREVIOUS YEAR COSTS AND WORKLOAD ARE PRESENTED AS NEGATIVE NUMBERS TO DETERMINE MARGINAL DIFFERENCES ONLY

U.S. ARMY GATEWAY TO CARE
COST SUMMARY INSTITUTIONAL & PROFESSIONAL SERVICES COSTS
FOR CARE END DATES OF 9010-9109 & 9110-9209
WHERE FISCAL YEAR 1991 = 9010-9109 / 1992 = 9110-9209

FACILITY BROOKE AMC FT SAM HOUSTON

		TOTAL PAID*INST+PROF SVC	TOTAL PAID*INSTITUTION	TOT PD*PROF SVCS	ADMISSIONS	TOTAL*BED DAYS	TOTAL*PROF SVCS	TOTAL*VISITS
CLINICAL CATEGORY:	IDX:FY-CARE END DATE							
DERMATOLOGY	1991	-158847.07	0.00	-158847.07	0.00	0.00	-4603.00	-1812.00
	1992	130200.40	0.00	130200.40	0.00	0.00	4715.00	1918.00
	DIFF	-28646.67	0.00	-28646.67	0.00	0.00	112.00	106.00
ENDOCRINOLOGY	IDX:FY-CARE END DATE							
	1991	-39586.62	0.00	-39586.62	0.00	0.00	-1084.00	-282.00
	1992	27386.25	0.00	27386.25	0.00	0.00	949.00	346.00
	DIFF	-12200.37	0.00	-12200.37	0.00	0.00	-135.00	64.00
ENT (EAR, NOSE, THROAT)	IDX:FY-CARE END DATE							
	1991	-393840.79	0.00	-393840.79	0.00	0.00	-6959.00	-3821.00
	1992	305249.91	0.00	305249.91	0.00	0.00	6546.00	4400.00
	DIFF	-88590.88	0.00	-88590.88	0.00	0.00	-413.00	579.00
FAMILY PRACTICE	IDX:FY-CARE END DATE							
	1991	-425524.83	0.00	-425524.83	0.00	0.00	-15774.00	-11745.00
	1992	358501.34	0.00	358501.34	0.00	0.00	12760.00	9568.00
	DIFF	-67023.49	0.00	-67023.49	0.00	0.00	-3014.00	-2177.00

(CONTINUED)

SOURCE: TRI-SERVICE CHAMPUS STATISTICAL DATABASE
FINANCIAL ANALYSIS SUPPORT SYSTEM (FASS)
U.S. ARMY HEALTH CARE STUDIES
FT. SAM HOUSTON, TX 78234-6000

* PREVIOUS YEAR COSTS AND WORKLOAD ARE PRESENTED AS
NEGATIVE NUMBERS TO DETERMINE MARGINAL DIFFERENCES ONLY

U.S. ARMY GATEWAY TO CARE
COST SUMMARY INSTITUTIONAL & PROFESSIONAL SERVICES COSTS
FOR CARE END DATES OF 9010-9109 & 9110-9209
WHERE FISCAL YEAR 1991 = 9010-9109 / 1992 = 9110-9209

FACILITY BROOKE AMC FT SAM HOUSTON

		TOTAL PAID*INST+PROF SVC	TOTAL PAID*INSTITUTION	TOT PD*PROF SVCS	ADMISSIONS	TOTAL*BED DAYS	TOTAL*PROF SVCS	TOTAL*VISITS
CLINICAL CATEGORY:	IDX:FY-CARE END DATE							
GASTROENTEROLOGY	1991	-476778.01	0.00	-476778.01	0.00	0.00	-7351.00	-836.00
	1992	245251.53	0.00	245251.53	0.00	0.00	4238.00	680.00
	DIFF	-231526.48	0.00	-231526.48	0.00	0.00	-3113.00	-156.00
GENERAL PRACTICE	IDX:FY-CARE END DATE							
	1991	-161661.51	0.00	-161661.51	0.00	0.00	-6033.00	-3345.00
	1992	119829.96	0.00	119829.96	0.00	0.00	3996.00	2470.00
	DIFF	-41831.55	0.00	-41831.55	0.00	0.00	-2037.00	-875.00
GENERAL SURGERY	IDX:FY-CARE END DATE							
	1991	-767734.14	0.00	-767734.14	0.00	0.00	-10368.00	-1843.00
	1992	556591.64	0.00	556591.64	0.00	0.00	10079.00	2294.00
	DIFF	-211142.50	0.00	-211142.50	0.00	0.00	-289.00	451.00
GYNECOLOGY	IDX:FY-CARE END DATE							
	1991	-430985.40	0.00	-430985.40	0.00	0.00	-13468.00	-4890.00
	1992	287161.77	0.00	287161.77	0.00	0.00	10535.00	4426.00
	DIFF	-143823.63	0.00	-143823.63	0.00	0.00	-2933.00	-464.00

(CONTINUED)

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U.S. ARMY GATEWAY TO CARE
COST SUMMARY INSTITUTIONAL & PROFESSIONAL SERVICES COSTS
FOR CARE END DATES OF 9010-9109 & 9110-9209
WHERE FISCAL YEAR 1991 = 9010-9109 / 1992 = 9110-9209

FACILITY BROOKE AMC FT SAM HOUSTON

		TOTAL PAID*INST+PROF SVC	TOTAL PAID*INSTITUTION	TOT PD*PROF SVCS	ADMISSIONS	TOTAL*BED DAYS	TOTAL*PROF SVCS	TOTAL*VISITS
CLINICAL CATEGORY:	IDX:FY-CARE END DATE							
HEMATOLOGY	1991	-27129.66	0.00	-27129.66	0.00	0.00	-571.00	-88.00
	1992	55420.57	0.00	55420.57	0.00	0.00	702.00	153.00
	DIFF	28290.91	0.00	28290.91	0.00	0.00	131.00	65.00
INFECTIOUS DISEASE	IDX:FY-CARE END DATE							
	1991	-44858.35	0.00	-44858.35	0.00	0.00	-1148.00	-379.00
	1992	34440.26	0.00	34440.26	0.00	0.00	1187.00	367.00
	DIFF	-10418.09	0.00	-10418.09	0.00	0.00	39.00	-12.00
INTERNAL MEDICINE	IDX:FY-CARE END DATE							
	1991	-459765.36	0.00	-459765.36	0.00	0.00	-16617.00	-10880.00
	1992	406476.21	0.00	406476.21	0.00	0.00	15339.00	10818.00
	DIFF	-53289.15	0.00	-53289.15	0.00	0.00	-1278.00	-62.00
NEPHROLOGY	IDX:FY-CARE END DATE							
	1991	-25040.76	0.00	-25040.76	0.00	0.00	-605.00	-235.00
	1992	25927.86	0.00	25927.86	0.00	0.00	574.00	227.00
	DIFF	887.10	0.00	887.10	0.00	0.00	-31.00	-8.00

(CONTINUED)

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CLINICAL CATEGORY:	IDX:FY-CARE END DATE							
NEUROLOGY	1991	-409784.41	0.00	-409784.41	0.00	0.00	-6082.00	-2129.00
	1992	333880.90	0.00	333880.90	0.00	0.00	6306.00	2612.00
	DIFF	-75903.51	0.00	-75903.51	0.00	0.00	224.00	483.00
NEUROSURGERY	IDX:FY-CARE END DATE							
	1991	-100178.74	0.00	-100178.74	0.00	0.00	-1633.00	-319.00
	1992	65112.77	0.00	65112.77	0.00	0.00	822.00	353.00
	DIFF	-35065.97	0.00	-35065.97	0.00	0.00	-811.00	34.00
NUTRITIONAL	IDX:FY-CARE END DATE							
	1991	-2538.87	0.00	-2538.87	0.00	0.00	-20.00	-3.00
	1992	1430.62	0.00	1430.62	0.00	0.00	24.00	4.00
	DIFF	-1108.25	0.00	-1108.25	0.00	0.00	4.00	1.00
OBSTETRICS	IDX:FY-CARE END DATE							
	1991	-62485.49	0.00	-62485.49	0.00	0.00	-805.00	-27.00
	1992	54569.94	0.00	54569.94	0.00	0.00	787.00	26.00
	DIFF	-7915.55	0.00	-7915.55	0.00	0.00	-18.00	-1.00

(CONTINUED)

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FACILITY BROOKE AMC FT SAM HOUSTON

		TOTAL PAID*INST+PROF SVC	TOTAL PAID*INSTITUTION	TOT PD*PROF SVCS	ADMISSIONS	TOTAL*BED DAYS	TOTAL*PROF SVCS	TOTAL*VISITS
CLINICAL CATEGORY:	IDX:FY-CARE END DATE							
OPHTHALMOLOGY	1991	-450975.31	0.00	-450975.31	0.00	0.00	-5765.00	-4055.00
	1992	357993.34	0.00	357993.34	0.00	0.00	4271.00	2916.00
	DIFF	-92981.97	0.00	-92981.97	0.00	0.00	-1494.00	-1139.00
ORTHOPEDICS	IDX:FY-CARE END DATE							
	1991	-633633.46	0.00	-633633.46	0.00	0.00	-9233.00	-3868.00
	1992	626346.01	0.00	626346.01	0.00	0.00	10427.00	4385.00
	DIFF	-7287.45	0.00	-7287.45	0.00	0.00	1194.00	517.00
OTHER (NOT ELSEWHERE CLASSIFIED)	IDX:FY-CARE END DATE							
	1991	-184368.03	0.00	-184368.03	0.00	0.00	-5377.00	-1781.00
	1992	208773.53	0.00	208773.53	0.00	0.00	5162.00	1544.00
	DIFF	24405.50	0.00	24405.50	0.00	0.00	-215.00	-237.00
PEDIATRICS	IDX:FY-CARE END DATE							
	1991	-499022.58	0.00	-499022.58	0.00	0.00	-21173.00	-16674.00
	1992	410935.28	0.00	410935.28	0.00	0.00	18450.00	15092.00
	DIFF	-88087.30	0.00	-88087.30	0.00	0.00	-2723.00	-1582.00

(CONTINUED)

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FACILITY BROOKE AMC FT SAM HOUSTON

		TOTAL PAID*INST+PROF SVC	TOTAL PAID*INSTITUTION	TOT PD*PROF SVCS	ADMISSIONS	TOTAL*BED DAYS	TOTAL*PROF SVCS	TOTAL*VISITS
CLINICAL CATEGORY:	IDX:FY-CARE END DATE							
PHYSICAL THERAPY	1991	-65034.85	0.00	-65034.85	0.00	0.00	-3344.00	-3160.00
	1992	459429.72	0.00	459429.72	0.00	0.00	25580.00	25184.00
	DIFF	394394.87	0.00	394394.87	0.00	0.00	22236.00	22024.00
PLASTIC SURGERY	IDX:FY-CARE END DATE							
	1991	-39194.91	0.00	-39194.91	0.00	0.00	-109.00	-18.00
	1992	54914.48	0.00	54914.48	0.00	0.00	155.00	39.00
	DIFF	15719.57	0.00	15719.57	0.00	0.00	46.00	21.00
PROCTOLOGY	IDX:FY-CARE END DATE							
	1991	-4027.21	0.00	-4027.21	0.00	0.00	-54.00	-6.00
	1992	3043.74	0.00	3043.74	0.00	0.00	36.00	7.00
	DIFF	-983.47	0.00	-983.47	0.00	0.00	-18.00	1.00
PSYCHIATRIC	IDX:FY-CARE END DATE							
	1991	-4232091.76	0.00	-4232091.76	0.00	0.00	-65608.00	-45288.00
	1992	3239805.56	0.00	3239805.56	0.00	0.00	53929.00	43293.00
	DIFF	-992286.20	0.00	-992286.20	0.00	0.00	-11679.00	-1995.00

(CONTINUED)

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		TOTAL PAID*INST+PROF SVC	TOTAL PAID*INSTITUTION	TOT PD*PROF SVCS	ADMISSIONS	TOTAL*BED DAYS	TOTAL*PROF SVCS	TOTAL*VISITS
CLINICAL CATEGORY:	IDX:FY-CARE END DATE							
PULMONARY/RESPIRATORY	1991	-541456.52	0.00	-541456.52	0.00	0.00	-6243.00	-2482.00
	1992	476544.38	0.00	476544.38	0.00	0.00	6058.00	2343.00
	DIFF	-64912.14	0.00	-64912.14	0.00	0.00	-185.00	-139.00
RHEUMATOLOGY	IDX:FY-CARE END DATE							
	1991	-120723.84	0.00	-120723.84	0.00	0.00	-2729.00	-1362.00
	1992	86658.19	0.00	86658.19	0.00	0.00	2086.00	973.00
	DIFF	-34065.65	0.00	-34065.65	0.00	0.00	-643.00	-389.00
THORACIC SURGERY	IDX:FY-CARE END DATE							
	1991	-141481.71	0.00	-141481.71	0.00	0.00	-585.00	-105.00
	1992	109174.71	0.00	109174.71	0.00	0.00	782.00	186.00
	DIFF	-32307.00	0.00	-32307.00	0.00	0.00	197.00	81.00
UROLOGY	IDX:FY-CARE END DATE							
	1991	-128084.41	0.00	-128084.41	0.00	0.00	-3010.00	-766.00
	1992	115677.91	0.00	115677.91	0.00	0.00	2937.00	712.00
	DIFF	-12406.50	0.00	-12406.50	0.00	0.00	-73.00	-54.00

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		TOTAL PAID*INST+PROF SVC	TOTAL PAID*INSTITUTION	TOT PD*PROF SVCS	ADMISSIONS	TOTAL*BED DAYS	TOTAL*PROF SVCS	TOTAL*VISITS
GRAND TOTAL	IDX:FY-CARE END DATE							
	1991	-11642231.22	0.00	-11642231.22	0.00	0.00	-230824.00	-125918.00
	1992	9576074.18	0.00	9576074.18	0.00	0.00	232246.00	141339.00
	DIFF	-2066157.04	0.00	-2066157.04	0.00	0.00	1422.00	15421.00

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WER164B     RESERVE REQUESTED       131072, USED     12431360
WER146B  EMERGENCY SPACE ALLOCATED   12288
WER410B  CORE ABOVE 16 MEG AVAIL     10485760, RESERVE REQUESTED          0,
WER410B     USED     10485760
WER037B  G =     58218
WER036B  B =       263
WER162B  DISK SORTWORK (TRACKS) JCL PRIM=000000, JCL SEC=000000,
WER162B     TOTAL DYNALLOC=001395, TOTAL REL=000120, USED=001275
WER151B  SECONDARY EXTENTS OBTAINED 003
WER045C  END SORT PH
WER055I  INSERT     327915, DELETE     327915
WER211B  SYNCSMF  CALLED BY SYNCSORT; RC=0000
WER416B  29 EXCP'S WERE ISSUED FOR SASSWORKS .
WER416B  29 TOTAL EXCP'S ISSUED FOR SORTING
WER246I  FILESIZE 57,713,040 BYTES
WER054I  RCD IN           0, OUT          0
WER169I  TPF LEVEL      4
WER052I  END SYNCSORT;- AAD:WRW1,STEP1    ,SAS607
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